

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11773

CERTIFICATE OF DEATH

117654
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Wesley</u> (Last) <u>Anderson</u>				4. DATE OF DEATH: (Month) <u>Dec.</u> (Day) <u>31</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>3-2-1863</u>	
9. AGE last birthday: <u>93</u> yrs.		10. MONTHS <u>93</u>		11. DAYS <u>93</u>		12. HOURS <u>93</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Below</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Unk -</u>		11. BIRTHPLACE (State or foreign country): <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME: <u>John Anderson</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Sugar</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service) <u>4 No</u>				16. SOCIAL SECURITY No.: <u>Unk</u>		17. INFORMANT & ADDRESS: <u>Lucille Johnson - St. Michaels, Md.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
443X Immediate cause (a) <u>arteriosclerotic cardiovascular disease</u>						20 of yrs	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>hypertension; endarteritis obliterans; ch. myocorditis; senility</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1935</u> , 19 <u>55</u> , to <u>31 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>30 Dec</u> , 19 <u>55</u> and that death occurred at <u>12:25 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL, (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-3-56</u>		<u>St. Luke's</u>		<u>St. Michaels, Carroll Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan. 2, 1956</u>		<u>C. Harry Wren</u>		<u>Arthur H. Haight</u>		<u>St. Michaels, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1956

RECEIVED

11766

STATE DEPARTMENT OF HEALTH

MARYLAND

11774

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fruitburg</u> TOWN <u>Fruitburg</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer Park Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fruitburg</u> TOWN <u>Fruitburg</u> STREET ADDRESS (If rural, give location) <u>Deer Park Rd. RFD #1</u>	
3. NAME OF DECEASED (Type or Print) <u>LEE</u> (First) <u>MILFORD</u> (Middle) <u>BAILEY</u> (Last)		4. DATE OF DEATH <u>December 2</u> 1955 (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 17, 1893</u> 9. AGE last birthday <u>62</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles L. Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Chiscomb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>176-65-3167</u>	
17. INFORMANT AND ADDRESS <u>George Bailey, RFD #1 Fruitburg, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Carcinoma, liver</u>			
Antecedent cause(s) (b) <u>1561</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>Sept 8</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 8</u> , 1955, to <u>Dec 2</u> , 1955, that I last saw the deceased alive on <u>Dec 2</u> , 1955, and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Clarence E. McWilliam, M.D.</u> (Degree or title)		ADDRESS <u>Keisterstown, Maryland</u> DATE SIGNED <u>Dec 2, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Dec 5-55</u> NAME OF CEMETERY OR CREMATORY <u>Carroll Reform</u> LOCATION (City, town, or county) <u>Faifield Pa.</u>	
DATE REC'D BY LOCAL REG. <u>12-3-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u> 24. FUNERAL DIRECTOR <u>J. F. Eline, Sons Rustington, Md.</u> ADDRESS	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

DEC 6 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11775

CERTIFICATE OF DEATH

11767

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Md.</u>		COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u> since <u>7-25-52</u>				TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hosp.</u>				STREET ADDRESS (If rural give location) <u>523 S. Kenwood Ave</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Anna Marie Baldwin</u>				<u>Dec. 25 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>fem.</u>	<u>white</u>	<u>mar.</u>	<u>4-12-1890</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>HOUSE WORK AT HOME</u>			<u>AT HOME</u>		<u>Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Ross</u>				<u>Florence Bishop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
					<u>records of Springfield State Hosp.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Chronic brain syndrome associated with</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>circulatory disturbance, cerebral arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>with psychotic reaction.</u>						<u>more than 10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>diabetes</u>						<u>3 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 25</u>, 19<u>52</u>, to <u>Dec. 25</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Dec. 25</u>, 19<u>55</u>, and that death occurred at <u>8:17 P.M.</u>, from the causes and on the date stated above.							
SIGNATURE <u>Martin Gross, M.D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Md.</u>			
				DATE SIGNED <u>Dec. 26, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-29-55</u>		<u>OAK LAWN CEM.</u>		<u>7225 EASTERN BLVD., MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 27 1955</u>		<u>C. Harry Sherris</u>		<u>Charles L. Fisher</u>		<u>9015 CONKLING ST. BALTO., MD.</u>	

CERTIFICATE OF DEATH

Form 10-1-54

NAME OF DECEASED _____

DATE OF DEATH _____

PLACE OF DEATH _____

AGE _____

SEX _____

RACE _____

EDUCATION _____

OCCUPATION _____

CAUSE OF DEATH _____

MANNER OF DEATH _____

DATE OF BURIAL _____

PLACE OF BURIAL _____

SIGNATURE OF DECEASED _____

SIGNATURE OF WITNESSES _____

SIGNATURE OF PHYSICIAN _____

SIGNATURE OF CORONER _____

SIGNATURE OF JURY _____

SIGNATURE OF JUDGE _____

SIGNATURE OF CLERK _____

SIGNATURE OF _____

SIGNATURE OF _____

SIGNATURE OF _____

SIGNATURE OF _____

SIGNATURE OF _____

SIGNATURE OF _____

SIGNATURE OF _____

SIGNATURE OF _____

SIGNATURE OF _____

BUREAU V. S.

DEC 28 1955

RECEIVED

RECORDED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11767

CERTIFICATE OF DEATH

12555

76

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>WESTMINSTER</u>		<u>13 YRS.</u>		TOWN <u>WESTMINSTER</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>165 E. GREEN</u>				STREET ADDRESS (If rural give location) <u>165 E. GREEN</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOSEPH</u> (Middle) <u>HENRY</u> (Last) <u>BANGE</u>				(Month) <u>DEC.</u> (Day) <u>31</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Select one)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>MARRIED</u>	<u>OCT. 21-1877</u>	<u>78</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>REAL FARMER</u>						<u>MD.</u>	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
<u>SIMON BANGE</u>				<u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>NO</u>				<u>219-03-7501</u>		<u>DAISY BANGE</u> <u>165 E. Green Westminister, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>Cardio Vascular Renal disease</u>				<u>1955</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(B) <u>with myocardial degeneration</u>							
(C) <u>Arteriosclerosis & mild</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				General <u>Feb 11-1954</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>1 Feb. 1954</u>				<u>Heart & lungs & transverse aorta</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb 11, 1954</u> , to <u>Dec 31, 1955</u> , that I last saw the deceased alive on <u>Dec 31, 1955</u> , and that death occurred at <u>11:45 P.</u> M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Wylem Speicher</u>				<u>Westminister Md</u>		<u>1/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JAN 4. 1956</u>		<u>DEER PARK CEM.</u>		<u>REISTERSTOWN, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1-6-56</u>		<u>Harriet Miller</u>		<u>Albanard & Son</u>		<u>Westminister, Md.</u>	

JAN 6 1956

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11776

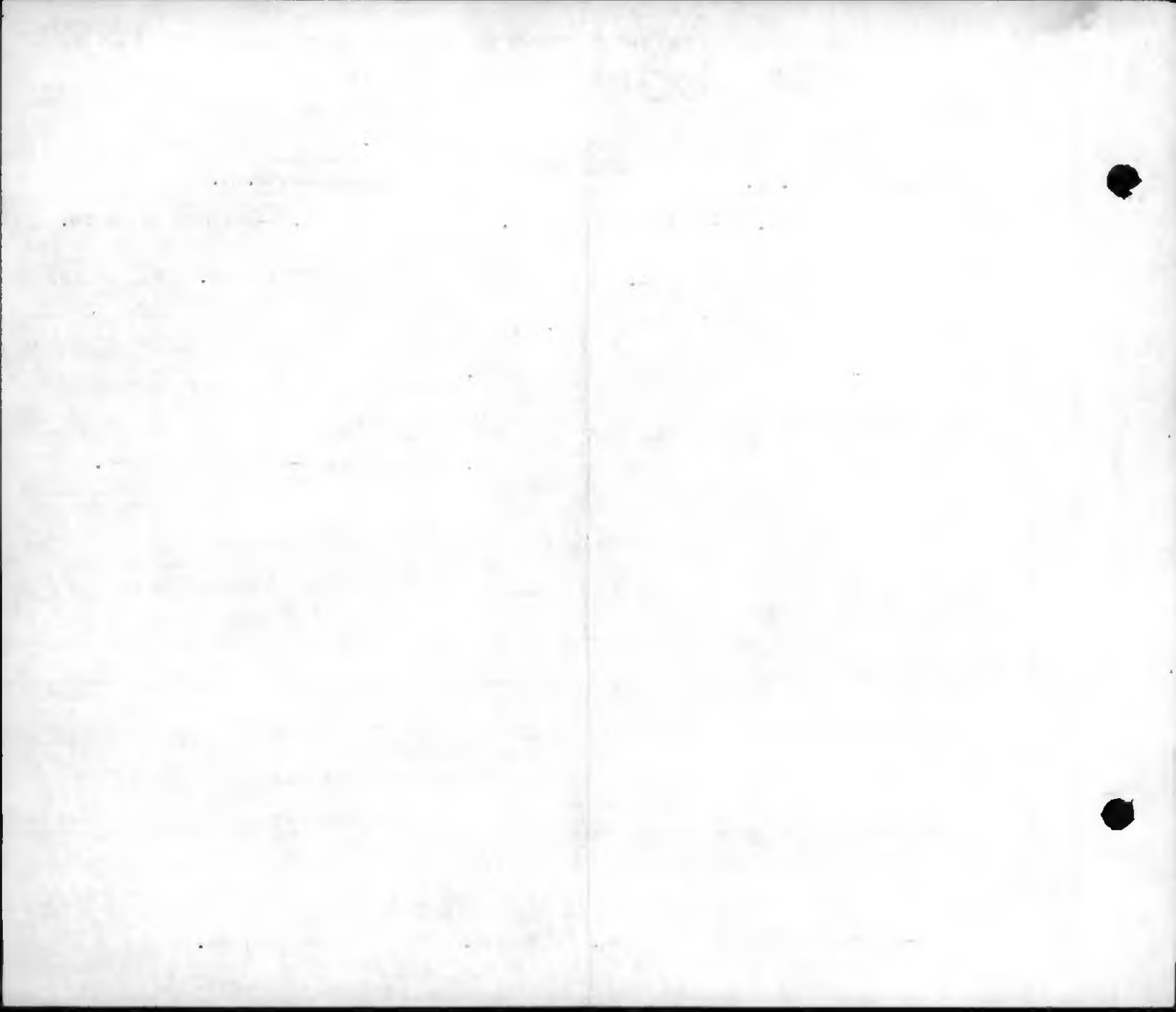
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville P. O.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville P. O.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route No. 1 - Oakland Mills Rd.</u>				STREET ADDRESS (If rural give location) <u>Route No. 1 - Oakland Mills Rd.</u>			
3. NAME OF DECEASED: (First) <u>ANNIE</u>		(Middle) <u>E.</u>		(Last) <u>BARNEY</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec. 27, 1955</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Nov. 7, 1863</u>		9. AGE last birthday: <u>92</u> yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS.: Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>-</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>James Sanders</u>				14. MOTHER'S MAIDEN NAME: <u>Rebecca Todd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Ruth Gisburne-Oakland Mills Rd.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardio-vascular Disease</u>							
ANTECEDENT CAUSE (B) <u>Arteriosclerosis & Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/26, 1955</u> , to <u>12/27, 1955</u> , that I last saw the deceased alive on <u>12/26/55</u> , 19... and that death occurred at <u>12/27 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm. E. Martin</u>				ADDRESS <u>M. D. Paudalltown, Ind.</u>		DATE SIGNED <u>12/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-removal</u>		DATE THEREOF <u>12/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem.</u>		LOCATION (City, town, or county) (State) <u>Hampton, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS <u>Wm. J. Tickers & Sons - Balt. 17 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11769

MARYLAND STATE DEPARTMENT OF HEALTH

11777

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERSReg. Dist. No. 70
80

1. PLACE OF DEATH- COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TANEYTOWN RURAL</u> LENGTH OF STAY (in this place) <u>1 year</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TANEYTOWN RURAL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>BETTY ELIZABETH BAUER LIEN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 12 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>MAY 15-1932</u>
9. AGE last birthday <u>23</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>employee of a retail store</u>		<u>employee of a retail store</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE MOSER</u>		14. MOTHER'S MAIDEN NAME <u>HELEN GRIME</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-28-7968</u>	
17. INFORMANT <u>HELEN MOSER - 5000 S. DORR RURAL</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Gunsight wound head and chestINTERVAL BETWEEN ONSET AND DEATH
4 minutes

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 12 12 55 10 m.INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Shot in head and chest with rifle22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Rem 14/55Ethel M. MehrengFuneral Home, Inc., 1000 S. DORR RURALLocal

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 26

11768
Iter. 2, Filed 1955-11-23-56 et.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll Co.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Westminster</u>		<u>Autopsy</u>		TOWN <u>Westminster, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<u>Center St (Stevenson Lane)</u>				<u>Center St (Stevenson Lane)</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EMMA</u> (Middle) <u>JANE</u> (Last) <u>BAUST</u>				(Month) <u>Dec</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	B. DATE OF BIRTH <u>March 16, 1867</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
				<u>Carroll Co. Md.</u>	<u>U.S.A.</u>		
13. FATHER'S NAME <u>David H. Wardlaw</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Reale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Harold M. Wardlaw, Jr. Westminster, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				<u>12-11-55</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension & Arteriosclerosis</u>				<u>Several yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Vascular Heart Disease</u>				<u>Several yrs</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 11-11-55</u> , 19 <u>55</u> , to <u>Dec 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 19</u> , 19 <u>55</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William Speicher</u> M.D.				ADDRESS (Street, city, town, state) <u>Dec 20-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 22, 55</u>		<u>Westminster Cem</u>		<u>Westminster, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Herbert Miller</u>		<u>J. E. Meyer, Jr.</u>		<u>Westminster, Md.</u>	
DATE <u>12-21-55</u>							

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11771

11778 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>since 8-8-55</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Monrovia</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print) <u>Windsor</u> (First) <u>-</u> (Middle) <u>BEALL</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 13th</u> 19 <u>55</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>May 5, 1883</u>		9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>		11. BIRTHPLACE (State or foreign country) <u>Monrovia, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Caleb A. Beall</u>				14. MOTHER'S MAIDEN NAME <u>Margaret L. Watkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Records of Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4 IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						<u>3-4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>						<u>more than 10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>-</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis with psychotic reaction.</u>						<u>more than 10 yrs.</u>	
19a. DATE OF OPERATION <u>-</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.) <u>-</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>-</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>-</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-</u>			
22. I hereby certify that I attended the deceased from <u>Sept. 10, 1955</u>, to <u>Dec. 13, 1955</u>, that I last saw the deceased alive on <u>Dec. 13, 1955</u>, and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Dec. 16, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bethesda Cemetery</u>		LOCATION (City, town, or county) (State) <u>Browningsville, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 16, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Damascus, Md.</u>	

RECEIVED

DEC 20 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11772

11779 CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Carroll</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	LENGTH OF STAY (In this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	TOWN <u>Manchester Md</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Manchester, Westminster Rd</u>	STREET ADDRESS (If rural give location) <u>Manchester, Westminster Rd</u>		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>George Peter Bipler</u>		<u>Dec 19 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Jan 5 1862</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Peter Bipler</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Earl Wentz, Westminster Md #12</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerotic Cardiovascular Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>			
19a. DATE OF OPERATION <u>Dec 15</u>	19b. MAJOR FINDINGS OF OPERATION <u></u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u></u>	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u></u>	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> <u></u>	21f. HOW DID INJURY OCCUR? <u></u>	
22. I hereby certify that I attended the deceased from <u>June 1, 1948</u> to <u>Dec 19, 1955</u> that I last saw the deceased alive on <u>Dec 15, 1955</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Dr. P. B. Bipler</u> M.D.		DATE SIGNED <u>Dec 19 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>12/22/55</u>	NAME OF CEMETERY OR CREMATORY <u>Reformed</u>	LOCATION (City, town, or county) (State) <u>Manchester Md</u>
24. REC'D BY REGISTRAR <u>Dec. 21-55</u>	REGISTRAR'S SIGNATURE <u>Mrs. W.P. Denner</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold B. Bipler</u> ADDRESS <u>Westminster Md</u>	

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11773

11780

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Rural - Sykesville</u>		<u>7 Mos. 26 days</u>		<u>Baltimore</u>		<u>3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>157 Springfield State Hospital</u>				<u>3316 Harmony Court</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE last birthday	
(First) <u>Felicia</u> (Middle) (Last) <u>BOONE</u>				(Month) <u>12</u> (Day) <u>4</u> (Year) <u>19 55</u>			
6. SEX	7. COLOR OR RACE	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	9. DATE OF BIRTH	10. AGE last birthday	11. IF UNDER 1 YEAR	12. IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>Widowed</u>	<u>2/7/88</u>	<u>67</u> yrs.	Months <u>12</u> Days <u>4</u>	Hours <u>19</u> Min. <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>				<u>Cuba</u>		<u>alien</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Phillip</u>				<u>Ella</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>2 days</u>			
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>years</u>			
STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <u>Chronic brain syndrome associated with senile brain disease, with psychotic reaction</u>				<u>2 - 3 years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/21</u> , 19 <u>55</u> , to <u>12/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/3</u> , 19 <u>55</u> , and that death occurred at <u>2:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Walter H. Sonnenfeldt</u> M.D.				<u>Sykesville, Maryland</u>		<u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>12/6/55</u>		<u>St. Anne's</u>		<u>German Hill Rd</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 6 1955</u>		<u>C. Gary Hays</u>		<u>J. J. Zahner</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 14 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

3. 11

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

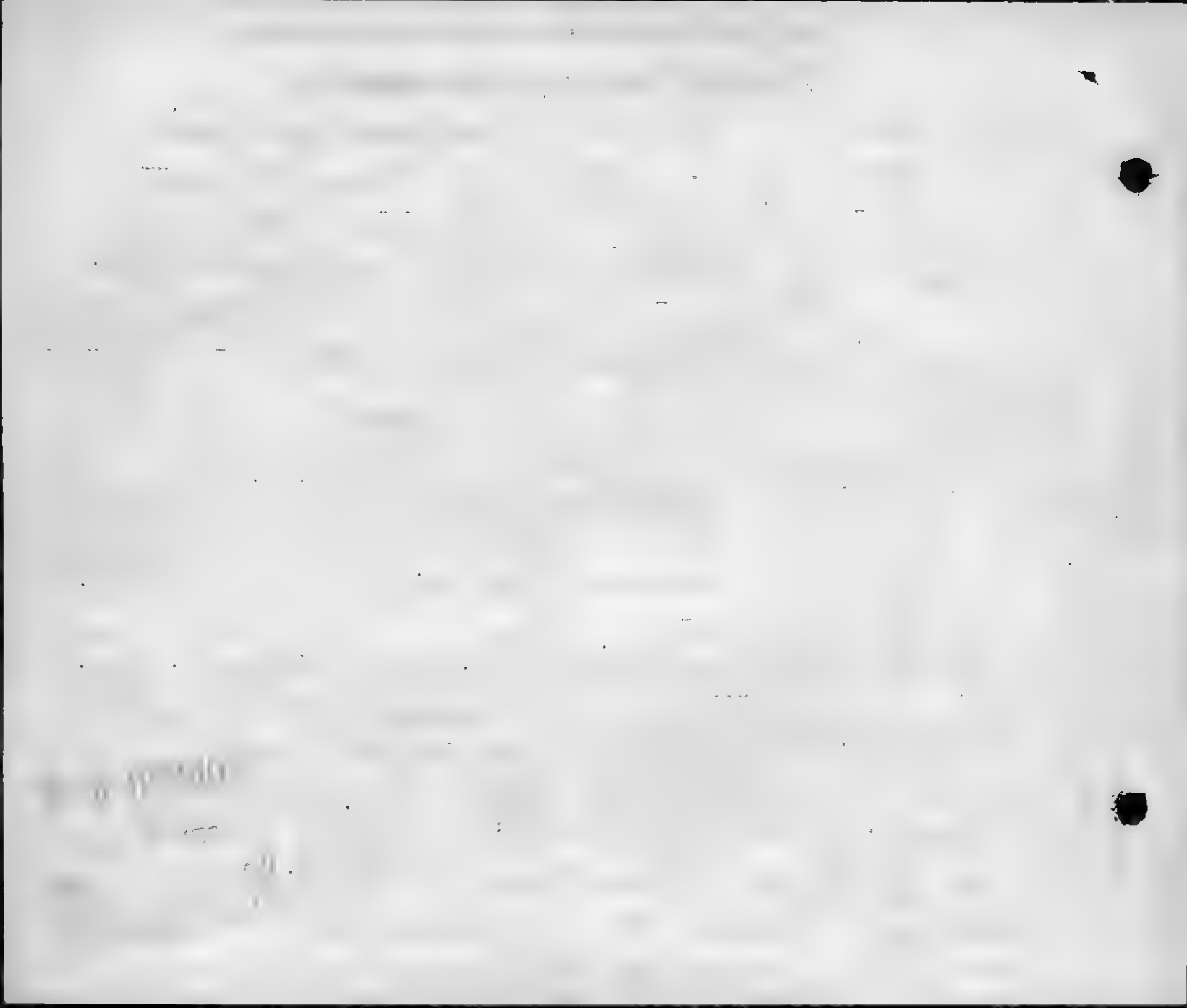
11774

11781 CERTIFICATE OF DEATH

Item 2, FilmGL90 12-28-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u> ?		COUNTY _____	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Rural - Sykesville</u>		<u>since 11-14-52</u>		TOWN <u>Baltimore</u> ?		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS <u>Unknown</u> (If rural give location)			
				<u>Found wandering in streets of Balto.</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Walker</u> (Middle) <u>—</u> (Last) <u>BOONE</u>		4. DATE OF DEATH (Month) <u>December</u> (Day) <u>13</u> (Year) <u>19 55</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>unknown</u>	8. DATE OF BIRTH <u>unknown</u>	9. AGE last birthday <u>about 63</u> yrs.		IF UNDER 1 YEAR (Months) _____ (Days) _____ IF UNDER 24 HRS. (Hours) _____ (Min.) _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unkn.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Records of Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>				<u>more than 10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDIT ON CAUSING DEATH. <u>CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</u>				<u>more than 10 yrs.</u>			
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>—</u>		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Min.) _____		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>January 22</u> 19 <u>53</u>, to <u>Dec. 13th</u> 19 <u>55</u>, that I last saw the deceased alive on <u>Dec. 13</u>, 1955, and that death occurred at <u>1:00 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Unburied & stored</u>		DATE THEREOF <u>12/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Univ. of Md. Med. School</u>		LOCATION (City, town, or county) <u>Baltimore, Md</u> (State) _____	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS _____	
DATE <u>12/13/55</u>							



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11782

CERTIFICATE OF DEATH

11775

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Henryton</u>		<u>7</u>		TOWN <u>Baltimore</u>		<u>3 Vol. 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Henryton State Hospital</u>				STREET ADDRESS (If rural give location) <u>3130 Belmont Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Phillip</u>		(Middle)		(Last) <u>Broughton</u>		(Month) (Day) (Year)	
						<u>12 10 19 55</u>	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>Colored</u>		<u>Single</u>		<u>10-31-15</u>	
						<u>40</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Not employed</u>				<u>Maryland</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Deceased</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>002X</u> IMMEDIATE CAUSE (A) <u>Cardiac insufficiency decompensated</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary tuberculosis, chronic</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 3</u>, 19<u>55</u>, to <u>Dec. 10</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Dec. 10</u>, 19<u>55</u>, and that death occurred at <u>12:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>T. F. Vesal</u>				ADDRESS (Street, city, town, state) <u>Henryton, Md.</u>		DATE SIGNED <u>12-10-55</u>	
				M.D.			
23. BURIAL, CREMATION, REMOVAE (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>							
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12-10-55</u>		<u>Albert R. [Signature]</u>		<u>Holland Funeral Home</u>		<u>1631 Duval Hill</u>	

UNITED STATES

DEC 15 1944

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11776

11783

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Rural - Sykesville</u>		<u>9 days</u>		TOWN <u>Baltimore</u>		<u>3Y 31.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>512 Park Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>DANIEL</u> (Middle) <u>PATRICK</u> (Last) <u>BROWN</u>				(Month) <u>12</u> (Day) <u>10</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Div.</u>	8. DATE OF BIRTH <u>5/21/84</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Parking attendant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>	11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Patrick Brown</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor O'Hare</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>211-20-7559</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0</u>						<u>5 years</u>	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Syphilis, undiagnosed site</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Pulmonary tuberculosis, far-advanced</u>						<u>5 years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>						<u>1 year</u>	
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/1</u> , 19 <u>55</u> , to <u>12/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/10</u> , 19 <u>55</u> , and that death occurred at <u>1:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>12-16-55</u>	NAME OF CEMETERY OR CREMATORY <u>New Catholic</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>C. Harvey Tucker</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>A.W. Meade</u>		ADDRESS <u>- 805 N. Calvert St.</u>			
DATE <u>Dec. 15, 1955</u>							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11777

11784

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>MARYLAND</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>Rural - Sykesville</u>		<u>16 days</u>		<u>Baltimore - 11</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2910 Huntington Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CHARLOTTE</u>		(Middle) <u>AGNES</u>		(Last) <u>BYUS</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>12/20/89</u>	
				9. AGE last birthday <u>65</u> yrs.		10. F UNDER 1 YEAR <u>1</u> MONTHS <u>1</u> DAYS	
						11. F UNDER 24 HRS. <u>19</u> HOURS <u>55</u> MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Noxema Company</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Daniel O'Connor</u>				14. MOTHER'S MAIDEN NAME <u>Margaret O'Connor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY NO. <u>215-13-4206</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Pulmonary embolism</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>				years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Carcinoma of left breast</u>				months			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Involutional psychotic reaction</u>				2 months			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>11/28</u> <u>55</u>				21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21b. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11/28</u> , 19 <u>55</u> , to <u>12/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>55</u> , and that death occurred at <u>9:20 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Springfield</u> M.D.				DATE SIGNED <u>12/2/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>12-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>	
24. REC'D BY REGISTRAR <u>12-5-55</u>				REGISTRAR'S SIGNATURE <u>C. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwab</u> ADDRESS <u>2101 Frederick Ave.</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 7

1. PLACE OF DEATH: Springfield State Hospital COUNTY, Carroll MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Near Sykesville, Maryland		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY CITY (If outside corporate limits write RURAL and give nearest town) TOWN Baltimore 27	
HOSPITAL OR INSTITUTION OR STREET ADDRESS None		STREET ADDRESS (If rural, give location) 5610 Carville Avenue	
3. NAME OF DECEASED: (Type or Print) Joseph Edward Carew		4. DATE OF DEATH 12 7 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Nov. 25, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): retired		10b. KIND OF BUSINESS OR INDUSTRY: Waterman	9. AGE last birthday: 73 yrs.
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY: USA	
13. FATHER'S NAME: Joseph Carew		14. MOTHER'S MAIDEN NAME: Martha Schible	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes		16. SOCIAL SECURITY No.: 217-141295	
17. INFORMANT & ADDRESS: Mrs. Velma Pritchett, daughter		5610 Carville Ave., Maryland, Balto. 27.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
423.1 Immediate cause (a) Acute Coronary Occlusion			0 minutes
Antecedent cause(s) (b) Myocardial Infarction			3 years
DISEASES OR CONDITIONS, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: --		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Shirley Barr</i>		M. D. <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED 12/7/55	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF: 12-10-55	NAME OF CEMETERY OR CREMATORY: Loudon Park	LOCATION (City, town, or county) (State): Baltimore
DATE REC'D BY LOCAL REG. 12-8-55	REGISTRAR'S SIGNATURE <i>Howard H. Hubbard</i>	24. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Ave	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53



11786

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Carroll</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>	LENGTH OF STAY (in this place) <u>22 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Sykesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Walter E Chenoweth</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec. 23, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>12-22-1902</u>
9. AGE last birthday <u>53</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>General</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Harry Chenoweth</u>		14. MOTHER'S MAIDEN NAME: <u>Rosanna Harkschneider</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-05-2846</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Martha Hart, 3706 Woodlawn Ave. Balt. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>Cerebral hemorrhage</u>		<u>30 hrs</u>	
(B) ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>arteriosclerotic cardiovascular disease with hypertension</u>		<u>15 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>U</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1941</u> , to <u>23 Dec., 1955</u> , that I last saw the deceased alive on <u>23 Dec., 1955</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. L. Lawrence</u>		DATE SIGNED <u>23 Dec. 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-27-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 24 1955</u>		REGISTRAR'S SIGNATURE <u>Robert R. Hewitt</u>	
24. FUNERAL DIRECTOR <u>Ulrich & Son</u>		ADDRESS <u>Home Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

RECEIVED

DEC 28 1955

BUREAU V. S.

11737

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>MARYLAND</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural - Sykesville</u>		<u>3Y, 2M, 6 days</u>		TOWN <u>Westminster</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>IDA</u> <u>BELLE</u> <u>DEAL</u>				<u>12</u> <u>14</u> <u>19 55</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Widowed</u>		<u>4/9/82</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>73</u> yrs.		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						<u>Unknown</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>IMMEDIATE CAUSE (A) <u>Thrombophlebitis, right leg</u></u>						<u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Chronic brain syndrome associated with senile brain disease, with psychotic reaction</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)						<u>4 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/1</u>, 19<u>55</u>, to <u>12/14</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12/13</u>, 19<u>55</u>, and that death occurred at <u>4:00 A.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Entombed + above</u>		<u>12/15/55</u>		<u>Univ of Md. Med. School</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>C. Harry Sherris</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11738

CERTIFICATE OF DEATH

Reg. Dist. No. 74

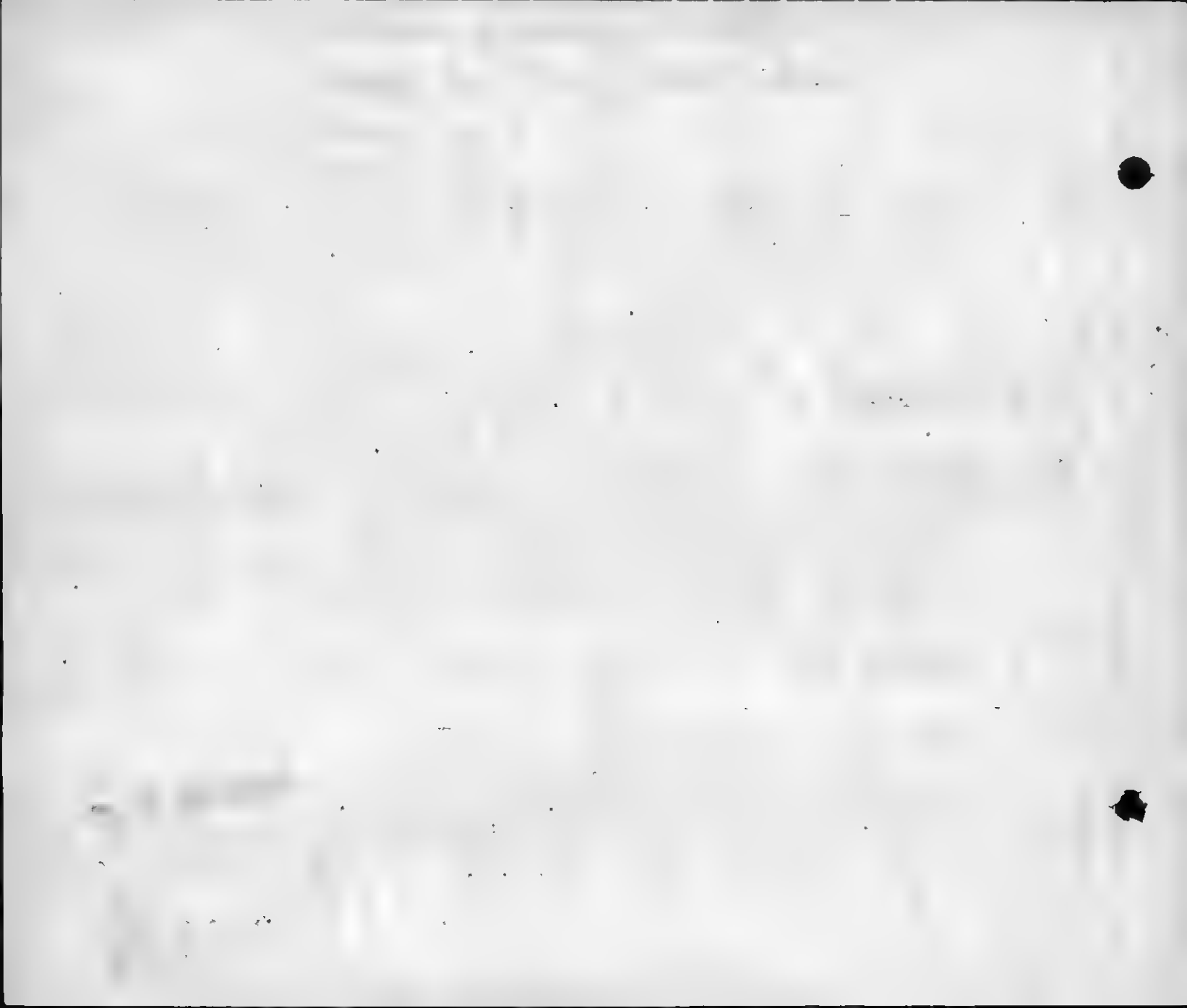
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>---</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>since 11-16-23</u>		TOWN <u>Baltimore City</u>		<u>3V01 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>409 N. Carrollton Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Victor</u> (Middle) <u>W.</u> (Last) <u>DIXON</u>				(Month) <u>December</u> (Day) <u>6</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>Single</u>	<u>January 2, 1882</u>	<u>73</u> yrs.	Months <u>---</u>	Days <u>---</u>	Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Clerk</u>		<u>Bottle-Cap Mfg.</u>		<u>Baltimore, Maryland</u>		<u>United States</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Dixon</u>				<u>Bettie J. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>unknown</u>		<u>Records of Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						<u>minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis and myocardial degeneration</u>						<u>more than 20 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Schizophrenic reaction, hebephrenic type</u>						<u>more than 30 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>---</u>		<u>---</u>		<u>YES</u>		<u>NO</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>		<u>---</u>		<u>---</u>		<u>---</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>---</u>		<u>M.</u>		<u>---</u>			
22. I hereby certify that I attended the deceased from <u>Sept. 1st, 19 47</u> to <u>Dec. 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 5</u> , 19 <u>55</u> , and that death occurred at <u>7:05 AM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Mark S. M. D. Martin Cross, M. D.</u>				<u>Sykesville, Maryland</u>		<u>12/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/9/55</u>		<u>Loudon Park Cem.</u>		<u>Balto., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 9 1955</u>		<u>C. Harry Myers</u>		<u>Wm. J. Dickerson & Sons - Balto.</u>		<u>17</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11789

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Sancti</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville, Maryland</u>	LENGTH OF STAY (In this place) <u>5 yrs, 2 mos.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westernport, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS <u>R.F.D. # 1</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Lula</u>	(Middle) <u>Frances</u>	(Last) <u>Duckworth</u>	(Month) <u>12</u> (Day) <u>28</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>10-25-1891</u>
9. AGE last birthday <u>64</u> yrs		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>unk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>unk</u>	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Owen Derflinger</u>		14. MOTHER'S MAIDEN NAME: <u>unk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>unk</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>unk</u>	
17. INFORMANT & ADDRESS: <u>Hospital records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE: <u>Coronary occlusion</u>			<u>30 min.</u>
(B) ANTECEDENT CAUSE (S): <u>Alzheimer's Disease</u>			<u>7 yrs.</u>
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>10-28-1950</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>10-28-1950</u> , to <u>12-28-1955</u> , that I last saw the deceased alive on <u>12-28-1955</u> , and that death occurred at <u>10:40 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Ilse Kamm, M.D.</u>		DATE SIGNED <u>12-29-55</u>	
ADDRESS <u>M.D. Springfield State Hosp., Sykesville, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. FUNERAL DIRECTOR ADDRESS	
DATE REC'D BY LOCAL REGISTRAR <u>Dec. 29, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Warr</u>	
NAME OF CEMETERY OR CREMATORY <u>Westernport</u>		LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11790

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		OR TOWN <u>Baltimore City</u>		OR TOWN	
TOWN <u>Sykesville</u>		<u>2 1/2 years +</u>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Herman</u> (Middle) <u>Eckmeyer</u> (Last)				(Month) <u>12</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed not known</u>	8. DATE OF BIRTH	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>not known</u>	
13. FATHER'S NAME <u>not known</u>				14. MOTHER'S MAIDEN NAME <u>not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or upk.) <u>not</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>not known</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>715X Sepsicemia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Decubitus ulcer</u>				<u>weeks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>904-7</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>General paresis</u>				<u>26 years + 3 mo +</u>			
<u>Fracture of neck of left femur</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>1-19-55</u> M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>knocked by a disturbed patient</u>			
22. I hereby certify that I attended the deceased from <u>July 19 1950</u> to <u>12-3 1955</u> that I last saw the deceased alive on <u>12-25 1955</u> and that death occurred at <u>2:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. J. J. J. J.</u> M.D.				ADDRESS (Street, city, town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>12/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>Greenview</u>		LOCATION (City, town, or county) (State) <u>Herman, Md</u>	
24. REC'D BY REGISTRAR <u>C. Harry Jones</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. J. J.</u>		ADDRESS	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155 1-55 10M

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11784

11769

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY Carroll	
CITY (If outside corporate limits, write RURAL or end give nearest town) Westminster		LENGTH OF STAY (In this place) 12 years		CITY (If outside corporate limits, write RURAL and give nearest town) Westminster			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 54½ Carroll Street				STREET ADDRESS (If rural give location) 54½ Carroll Street			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Florence Sarah Fitze				4. DATE OF DEATH (Month) (Day) (Year) Dec. 1 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 12, 1873	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME T. John E. Hesson				14. MOTHER'S MAIDEN NAME Mary Harner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. no		17. INFORMANT & ADDRESS Rachel Fitze Westminster, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) Ante Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 24 hours			
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				General Cerebro-Atherosclerosis 10 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/30/55 to 12/1/55, that I last saw the deceased alive on 12/1/55, and that death occurred at 8 A.M. from the causes and on the date stated above.							
SIGNATURE William R. B...		M.D.		ADDRESS (Street, city, town, state) Westminster, Md.		DATE SIGNED 12/2/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 3, 1955		NAME OF CEMETERY OR CREMATORY Baust Cemetery		LOCATION (City, town, or county) (State) Tyrone, Maryland	
24. REC'D BY REGISTRAR DATE 12-3-55		REGISTRAR'S SIGNATURE Harold Miller		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Md.	

10. 2. 1954

10. 2. 1954

10. 2. 1954

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11791

CERTIFICATE OF DEATH

Reg. Dist. No. 11785

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>HANOVER</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodbine</u>	LENGTH OF STAY (In this place) <u>4 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HANOVER</u>	<u>181-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Waitzel Nursing Home</u>		STREET ADDRESS (If rural give location) <u>R. F. D.</u>	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>SARAH A.</u>	(Middle) <u>FLOHR</u>	(Last)	DATE OF DEATH: <u>Dec 16 1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>5/19/1876</u>
9. AGE last birthday <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME: <u>Joseph Massey</u>	14. MOTHER'S MAIDEN NAME: <u>Mary Jones</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war and dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: <u>John B. Flohr, 15 Magnolia Ave, Catonsville, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>		<u>7 years</u>
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1955, to Dec., 1955, that I last saw the deceased alive on December 15, 1955, and that death occurred at 2:05 P.M., from the causes and on the date stated above.

SIGNATURE <u>W.B. Culwell</u>	ADDRESS <u>Int. Army, Md.</u>	DATE SIGNED <u>12/16/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>12/19/55</u>	NAME OF CEMETERY OR CREMATORY <u>Springfield</u>
DATE REC'D BY LOCAL REGISTRAR <u>DEC 21 1955</u>	REGISTRAR'S SIGNATURE <u>Edna Hewitt</u>	24. FUNERAL DIRECTOR <u>Wm. Webb & Son</u>
		ADDRESS <u>28</u>

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A. 100

5

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11792

CERTIFICATE OF DEATH

11786

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>4Y, 4M, 21 days</u>		TOWN <u>Rockville</u>		<u>15-26-55</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ROSA</u> (Middle) <u>ALICE</u> (Last) <u>CROSHON</u>				(Month) <u>12</u> (Day) <u>12</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>White</u>	<u>Widowed</u>	<u>6/8/79</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>none</u>		<u>Frederick County, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Louis Craver</u>				<u>Laura Ramsburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>						<u>years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Chronic brain syndrome associated with senile brain disease, senile Parkinsonism</u>						<u>6 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/11</u> , 19 <u>55</u> , to <u>12/12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/11</u> , 19 <u>55</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walker H. Thompson, M.D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>DEC. 14, 1955</u>		<u>LAYTONSVILLE CEMT</u>		<u>LAYTONSVILLE, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber, Laytonsville Md</u>			
<u>DEC. 15, 1955</u>		<u>C. Harry W...</u>					

20.8.8

1.1.1

1.1.1

11793

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural- Sykesville</u>		LENGTH OF STAY (in this place) <u>27Y 2M 28 D</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>3VC1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>3700 East Pratt Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Margaret</u> (Middle) <u>Martha</u> (Last) <u>GROSS</u>				DATE (Month) (Day) (Year) <u>12</u> <u>5</u> <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>8/1/93</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u> <u>USA</u>	
13. FATHER'S NAME <u>Robert Gross</u>				14. MOTHER'S MAIDEN NAME <u>Belle Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>24 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>cerebral arteriosclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized arteriosclerosis</u>						<u>years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Epilepsy with mental deficiency</u>						<u>years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/4</u> <u>1955</u> , to <u>12/5</u> <u>1955</u> that I last saw the deceased alive on <u>12/4</u> <u>1955</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Sonnenfeldt</u>		M.D.		ADDRESS (Street, city, town, or county) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 8-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cook-Laurie</u>		LOCATION (City, town, or county) (State) <u>Eastern Bldg.</u>	
24. REC'D BY REGISTRAR DATE <u>DEC</u>		REGISTRAR'S SIGNATURE <u>C. Harry Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		ADDRESS <u>Essex</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



11794

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville</u>		LENGTH OF STAY (in this place) <u>9 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		<u>01</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>801 Bedford Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>SHANLON AMBROSE HARDMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 11 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-8-64</u>	9. AGE last birthday <u>91</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk -</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi Hardman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443x IMMEDIATE CAUSE (A) <u>Terminal pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive heart disease</u>				<u>years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis, simple deterioration.</u>				12 yr. +			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-28</u> , 19 <u>55</u> , to <u>12-11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-11</u> , 19 <u>55</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>A. Lubizka</u>		ADDRESS (Street, city, town, state) <u>M.D. Springfield State Hosp. Sykesville</u>		DATE SIGNED <u>12-11-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-14-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>12-12-55</u>		REGISTRAR'S SIGNATURE <u>A. Harry Weir</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Allen Inc.</u>		ADDRESS <u>Cumberland, Md.</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be delivered for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

DEC 15 1955

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

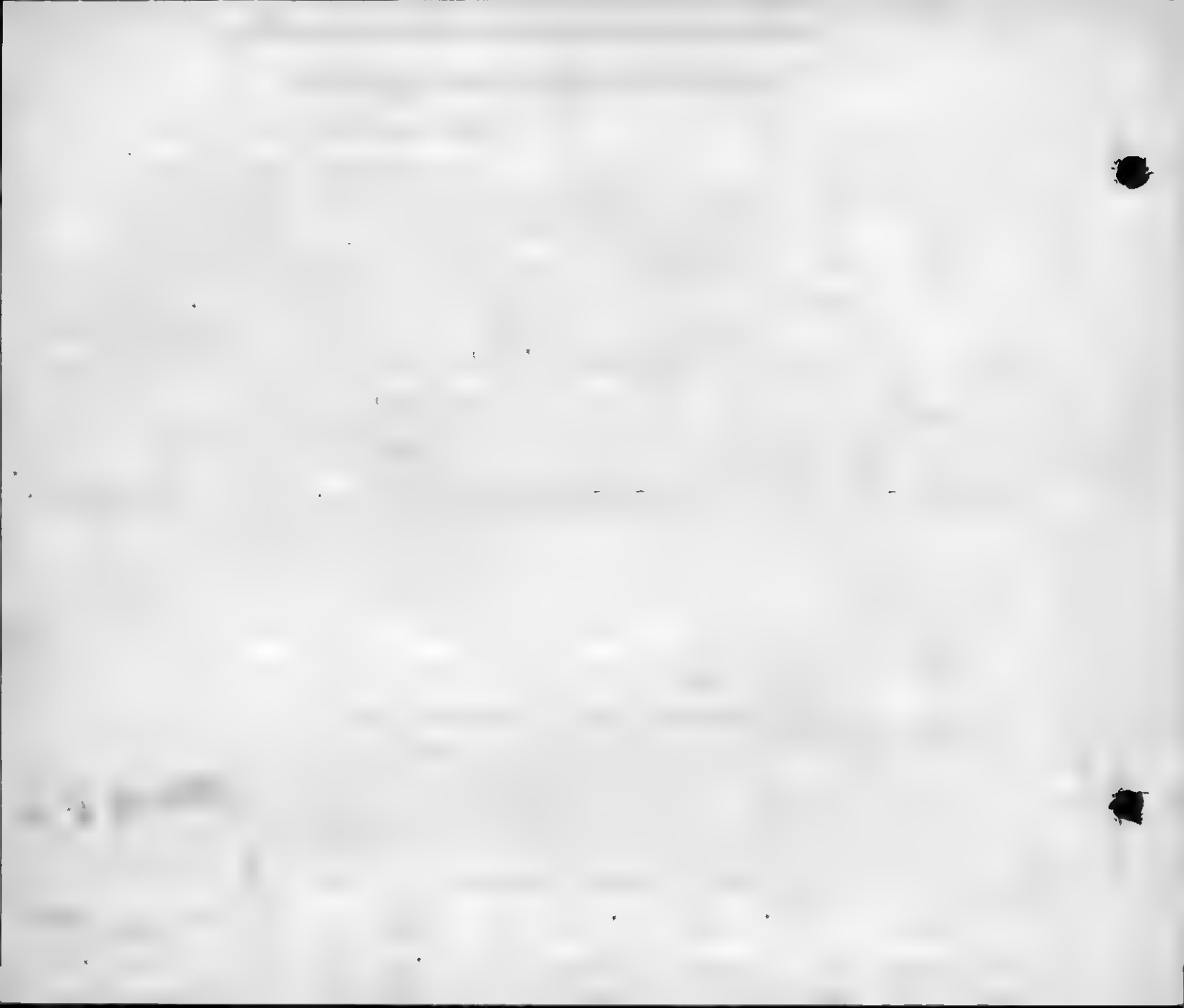
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11795 CERTIFICATE OF DEATH

11789

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE MARYLAND		STATE Maryland		COUNTY Carroll	
CITY (If outside corporate limits, write RURAL and give nearest town) rural Westminster		LENGTH OF STAY (In this place) 50 years		CITY (If outside corporate limits, write RURAL and give nearest town) rural Westminster			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 19 Locust Street				STREET ADDRESS (If rural give location) 19 Locust Street			
3. NAME OF DECEASED (Type or Print) Augustus George Humbert				4. DATE OF DEATH (Month) Dec. (Day) 4 (Year) 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH Oct. 24, 1869	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Silver Run, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Humbert				14. MOTHER'S MAIDEN NAME Sarah Gunder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 219-12-0084		17. INFORMANT & ADDRESS Clarence A. Humbert Westminster, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) Cerebral hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 5-6 days	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis						6+ yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) _____							
STATING UNDERLYING CAUSE LAST.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 1953 to Dec 4, 1955 that I last saw the deceased alive on Dec 3, 1955 and that death occurred at 15 Kenner ave Westminster from the causes and on the date stated above.							
SIGNATURE Wesley Wilkins		DATE THEREOF Dec. 6, 1955		NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		LOCATION (City, town, or county) Silver Run, Maryland	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial							
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE John R. Byers		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Md.			
DATE 11-6-55							



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11790

11796

CERTIFICATE OF DEATH

Reg. Dist. No. 13

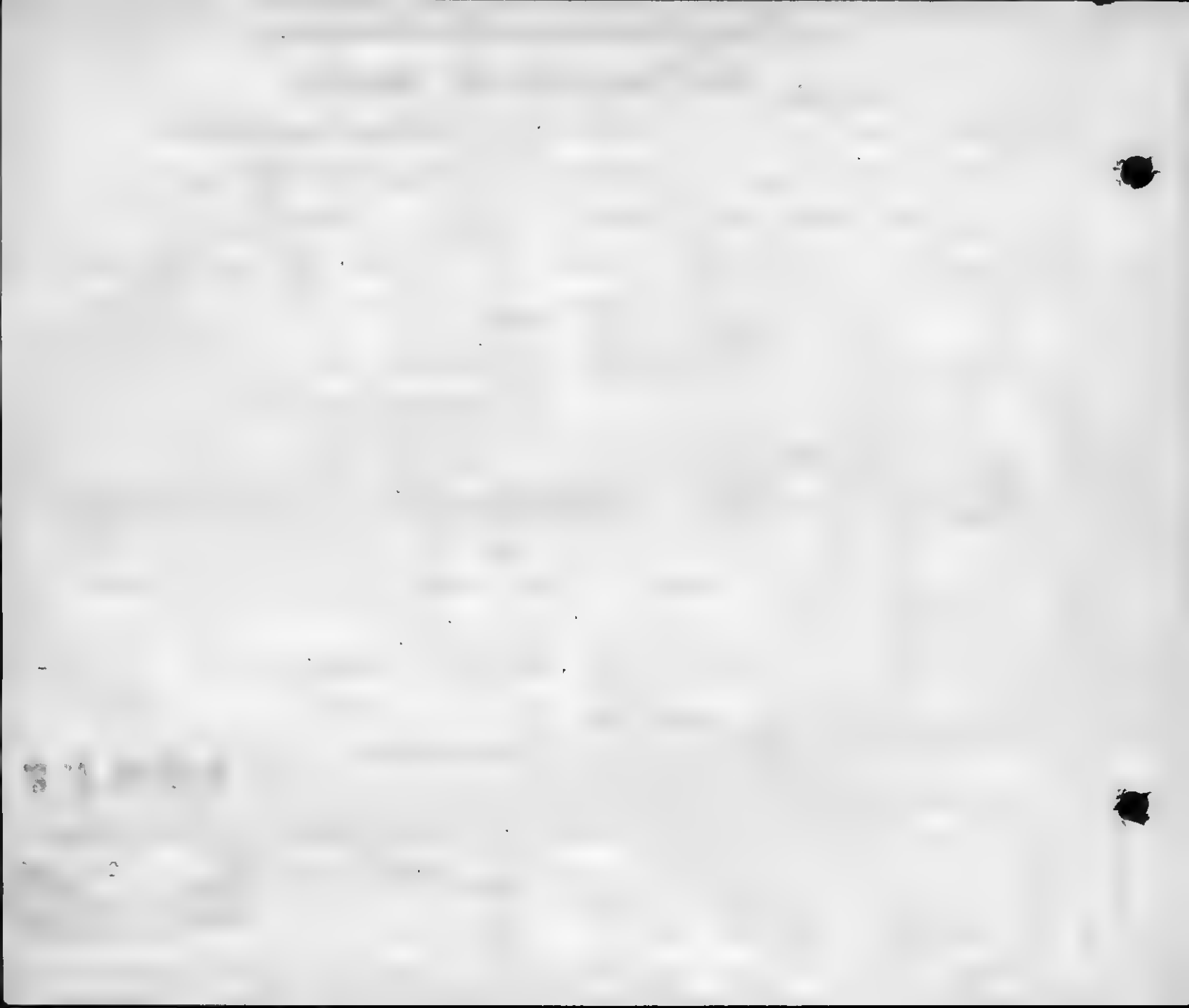
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Rural - Sykesville</u>		<u>4 months</u>		OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
<u>15</u> <u>Springfield State Hospital</u>		<u>920 N. Castle Street</u>					
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>FRANCES DALESICKY JECELIN</u>				<u>12 4 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Widowed</u>	<u>10/14/75</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>				<u>Czechoslovakia (Bohemia)</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>unknown</u>		<u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>443X</u> IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(B) <u>Hypertensive cardiovascular disease</u>						<u>years</u>	
(C) <u>Generalized arteriosclerosis</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>						<u>1 year/4</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/21</u> , 19 <u>55</u> , to <u>12/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/4</u> , 19 <u>55</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Walther H. Sonnenfeldt M.D.</u>				<u>Sykesville, Maryland</u>		<u>12/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-8-1955</u>		<u>OAK HILL</u>		<u>BALTIMORE MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12/5 1955</u>		<u>FR. CVACH & SON</u>		<u>900 N. CHESTER ST.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11791

11797

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY <u>CARROLL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> LENGTH OF STAY (in this place) TOWN <u>Springfield State Hosp</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> City <u>3111</u> OR TOWN STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>ROZELLA</u> (Middle) <u>E.</u> (Last) <u>JOHNS</u>		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>25</u> (Year) <u>55</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6-30-1875</u>
9. AGE last birthday <u>80</u> yrs.		10. IF UNDER 1 YEAR (Months) <u>5</u> (Days) <u>25</u> IF UNDER 24 HRS. (Hours) <u>-</u> (Min.) <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sch. teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard H. Johns</u>		14. MOTHER'S MAIDEN NAME <u>Eurith E. Leach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT & ADDRESS <u>Millie Register (sister) 6823 Thomas Blvd. Pittsburgh, PA.</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH (A) IMMEDIATE CAUSE <u>Acute mesenteric Thrombosis</u> (B) ANTECEDENT CAUSE(S) DUE TO <u>arterio sclerosis</u> (C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Schizophrenia - Paranoid Type</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u>	
19a. DATE OF OPERATION <u>12-25</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9-9</u> , 19 <u>36</u> , to <u>12-25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-25</u> , 19 <u>55</u> , and that death occurred at <u>6:05</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>Lucas R. Hoffman</u> M.D.		DATE SIGNED <u>12-25-55</u>	
ADDRESS (Street, city, town, state) <u>Springfield State Hosp.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-27-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>C. Henry Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Moore</u> ADDRESS <u>10820 North Ave</u>	
DATE <u>12-25-55</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BURMAN V. S.

DEC 23 1955

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INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **4 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11792

11798

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Frederick Co.</u>		<u>121</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville</u>		LENGTH OF STAY (In this place) <u>7 months 25 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital.</u>		STREET ADDRESS (If rural give location) <u>36 Franklin St.</u>					
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Bessie Elizabeth Kemp</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 30 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10-23-1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <u>Charwoman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Id and William Peddicord</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wolfe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Mrs Eleanor Sheckles</u> <u>36 Franklin St. Frederick, Md. (daughter)</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Hypertensive cardio-vascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>C.B.S. associated with circulatory disturbance other than cerebral arteriosclerosis with psychotic reaction</u>						<u>two years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-5</u> , 19 <u>55</u> , to <u>12-30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-30</u> , 19 <u>55</u> , and that death occurred at <u>2:15 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walker H Sommerfeldt</u>				ADDRESS (Street, city, town, state) <u>M.D. Springfield State Hospital</u>		DATE SIGNED <u>12-30-1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Frederick Md</u>		LOCATION (City, town, or county) <u>Frederick Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Wilson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u>		ADDRESS <u>Frederick Md</u>	
DATE <u>Dec. 31, 1955</u>							

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11793

11770

CERTIFICATE OF DEATH

Reg. Dist. No. *6*

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <i>Westminster</i>		<i>3 months</i>		OR TOWN <i>Baltimore City</i>		<i>CV 21-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>48 Longwell Ave.</i>				STREET ADDRESS (If rural give location) <i>1216 N. Calvert St.</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>SALLIE ELIZABETH LANE</i>				<i>Dec. 10 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>F.</i>	<i>W.</i>	<i>Married</i>	<i>Aug. 15, 1877</i>	<i>78</i> yrs.	Months	Days	Hours
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>housewife</i>					<i>St. Louis, Mo. U.S.A.</i>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Alexander J. Bowen</i>				<i>Betty Williams</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>Yes, give war or dates of service</i>						<i>Mrs. Cass. D. Schaffer, Westminster</i>	
18. MEDICAL CERTIFICATION				19. DATE OF OPERATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4222 IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<i>myocardial degeneration</i>				<i>2 yrs.</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug 1, 1955, to Dec 10, 1955 that I last saw the deceased alive on Dec 9, 1955, and that death occurred at 3:15 PM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>C. Reese Holcomb</i>				<i>Westminster</i>		<i>1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Dec. 19, 55</i>		<i>Baldwin Memorial</i>		<i>Westminster, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>12-11-55</i>		<i>Herbert J. ...</i>		<i>Wm. Cook ...</i>		<i>Baltimore</i>	

ST. LOUIS

SEP 10 1930

LIBRARY

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11794

11799

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Manchester</u>		LENGTH OF STAY (In this place) <u>15 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>✓</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ANNA - MAE - LEISTER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 30 19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 21 - 1930</u>	9. AGE last birthday <u>25</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stuck</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles Koernak</u>				14. MOTHER'S MAIDEN NAME <u>Sadie M Shaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-26-8878</u>		17. INFORMANT & ADDRESS <u>Harold A Lister - Manchester Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						<u>2 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Hemorrhage</u>						<u>5 minutes</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>September 19 50</u> , to <u>December 1930</u> , <u>1955</u> that I last saw the deceased alive on <u>12-29</u> , 19 <u>55</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. H. Howard</u>		M.D. <u>Manchester, Md.</u>		ADDRESS (Street, city, town, state) <u>12-30-55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 2-55</u>		NAME OF CEMETERY OR CREMATORY <u>Snyderburg</u>		LOCATION (City, town, or county) (State) <u>Carroll co Md</u>	
24. REC'D BY REGISTRAR <u>Dec. 31-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. W. H. Denner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edw A Tipton - Hampstead Md</u>		ADDRESS	

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RECEIVED

INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C-155 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

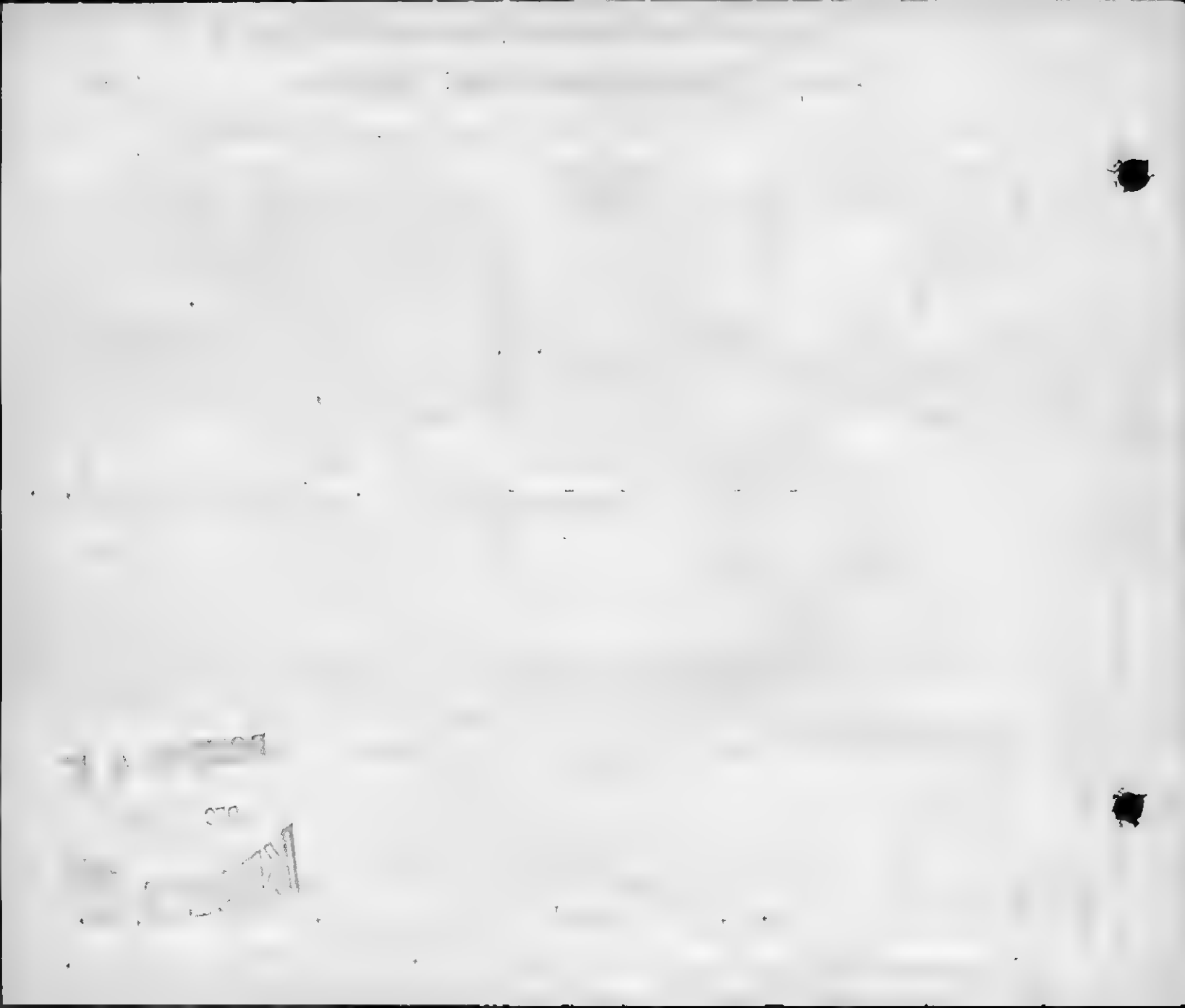
11890

CERTIFICATE OF DEATH

11795

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Maryland		COUNTY Carroll			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN rural Westminster		life		TOWN rural Westminster			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R 4 Gorsuch Road				STREET ADDRESS (If rural give location) R 4 Gorsuch Road			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Elizabeth (Middle) Keziah (Last) Leister				(Month) Dec. (Day) 15 (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
Female	White	Married	Feb. 18, 1885	70 yrs.	Months Days 	Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Housewife		Own Home		Carroll County, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Aaron Shaffer				Mary Bankert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		(If Yes, give war or dates of service)		Howard J. Leister Westminster, Md.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							year
IMMEDIATE CAUSE (A) <i>Generalized Arteriosclerosis</i>							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1950, to 12/15, 1955, that I last saw the deceased alive on 12-15, 1955, and that death occurred at 3:45 P.M. from the causes and on the date stated above.							
SIGNATURE <i>James J. Marsh</i>				DATE SIGNED 12/16/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
Burial				DATE 12-18-55			
DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
Dec. 19, 1955		Krider's Cemetery		nr. Westminster, Md.			
25. FUNERAL DIRECTOR'S SIGNATURE				26. FUNERAL DIRECTOR'S ADDRESS			
John R. Byers				Westminster, Md.			



INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** This law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11801

CERTIFICATE OF DEATH

11796

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Orchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sykesville, Maryland</u>		<u>1 yr. 8 mo. 2 days</u>		TOWN <u>Cambridge</u>		<u>6/13/55</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>301 Peach Blossom Street</u>			
3. NAME OF DECEASED (Type or Print) <u>THELMA LEWIS</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>12</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>5-29-13</u>	
9. AGE last birthday <u>42 yrs.</u>		IF UNDER 1 YEAR (Months) <u></u> (Days) <u></u>		IF UNDER 24 HRS. (Hours) <u></u> (Min.) <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Blanche Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>0</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pulmonary Embolism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>42 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Heart Fibrillation</u>						<u>Unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Pulmonary Tuberculosis</u>						<u>Approx. 2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with convulsive disorder, psychotic reaction.</u>						<u>20 years</u>	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED White <input type="checkbox"/> el work Not white <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3-16</u> , 19 <u>55</u> , to <u>12-12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-12</u> , 19 <u>55</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter J. Sonnenfeldt</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12-12-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Vicanna Cemetery</u>		LOCATION (City, town, or county) (State) <u>Vicanna Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward H. Hubbard</u>		ADDRESS <u>4107 Wilkens ave</u>	

VB/clm

U. S.

DEC 10

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11797

11802

CERTIFICATE OF DEATH

Iter 8, Film 190 12-27-55 et

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll Co.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural, Westminster</u>		<u>7 yrs.</u>		TOWN <u>Rural, Westminster</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Westminster RD #5</u>				STREET ADDRESS <u>Liberty St. 1st St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>SARAH JANE MANGER</u>				<u>DEC. 14 19 55</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 24, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Ephraim Manger Brown</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE <u>arteriosclerotic heart disease</u>				<u>with fibrillar</u>			
ANTECEDENT CAUSE(S) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>2 yrs</u>			
STATING UNDERLYING CAUSE LAST, DUE TO				<u>8 yrs</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 13, 1955</u> to <u>Dec 14, 1955</u> that I last saw the deceased alive on <u>Dec 13, 1955</u> and that death occurred at <u>12:45 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>W. C. Schilbers</u>				ADDRESS (Street, city, town, state) <u>Westminster, Md.</u>			
DATE <u>Dec 16, 55</u>				DATE SIGNED <u>12/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Dec. 16, 55</u>		<u>Proctor Cemetery</u>		<u>Rural, Westminster, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12-15-55</u>		<u>Harriet G. Zuber</u>		<u>J. E. Meyer, Jr.</u>		<u>Westminster, Md.</u>	



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11798

CERTIFICATE OF DEATH

Reg. Dist. No. 74

11803

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural		LENGTH OF STAY (In this place) 3 yrs 2 Mo.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.				STREET ADDRESS (If rural give location) 24 e. Lanvale St.			
3. NAME OF DECEASED (Type or Print) John T. Mc Auliffe				4. DATE OF DEATH (Month) 12 (Day) 23 (Year) 19 55			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH ? ? 18 74	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR Months 23 Days 19		IF UNDER 24 HRS. Hours 55 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Donhue				14. MOTHER'S MAIDEN NAME Hanora Donhue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT & ADDRESS Records of Springfield Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Cerebro-Vascular Accident						INTERVAL BETWEEN ONSET AND DEATH 20 Minutes	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Hypertensive						15 Yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Vascular Disease							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 12-24-55		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 6 , 19 52 , to Dec. 23 , 19 55 , that I last saw the deceased alive on Dec. 23 , 19 55 , and that death occurred at 11 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Signer: Radosky Remyak</i>				ADDRESS (Street, city, town, state) 55 H		DATE SIGNED 12-24-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-24-55		NAME OF CEMETERY OR CREMATORY New Cathedral		LOCATION (City, town, or county) (State) Baltimore Md.	
24. REC'D BY REGISTRAR DATE 12 24-55		REGISTRAR'S SIGNATURE <i>C. Harry Zuer</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>H. H. Mears</i> ADDRESS 805 N. Calvert St.			

BOOTH V. O.

DEC 20 1900

RECEIVED

11804

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sykesville</u>		<u>24 years</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2821 Chesterfield Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anna</u> (Middle) <u>Marie</u> (Last) <u>Meisel</u>				(Month) <u>Dec.</u> (Day) <u>9</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married W</u>	<u>9-18-1891</u>	<u>64</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Cigarette maker</u>		<u>---</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Schoenholtz</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Fleishman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No.</u>		<u>---</u>		<u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
025X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				<u>General Paresis</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis with Cerebro-spinal syphilis</u>				<u>Years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>2</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-25</u> , 19 <u>31</u> , to <u>12-9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-9</u> , 1955, and that death occurred at <u>9:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Gertrude S. ...</u>				DATE SIGNED <u>12/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 12, 1955</u>		<u>Sacred Heart Cemetery</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec 10, 1955</u>		<u>C. Henry ...</u>		<u>Leonard J. Ruck</u>		<u>5305 Harford Road #14</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

DEC 15 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

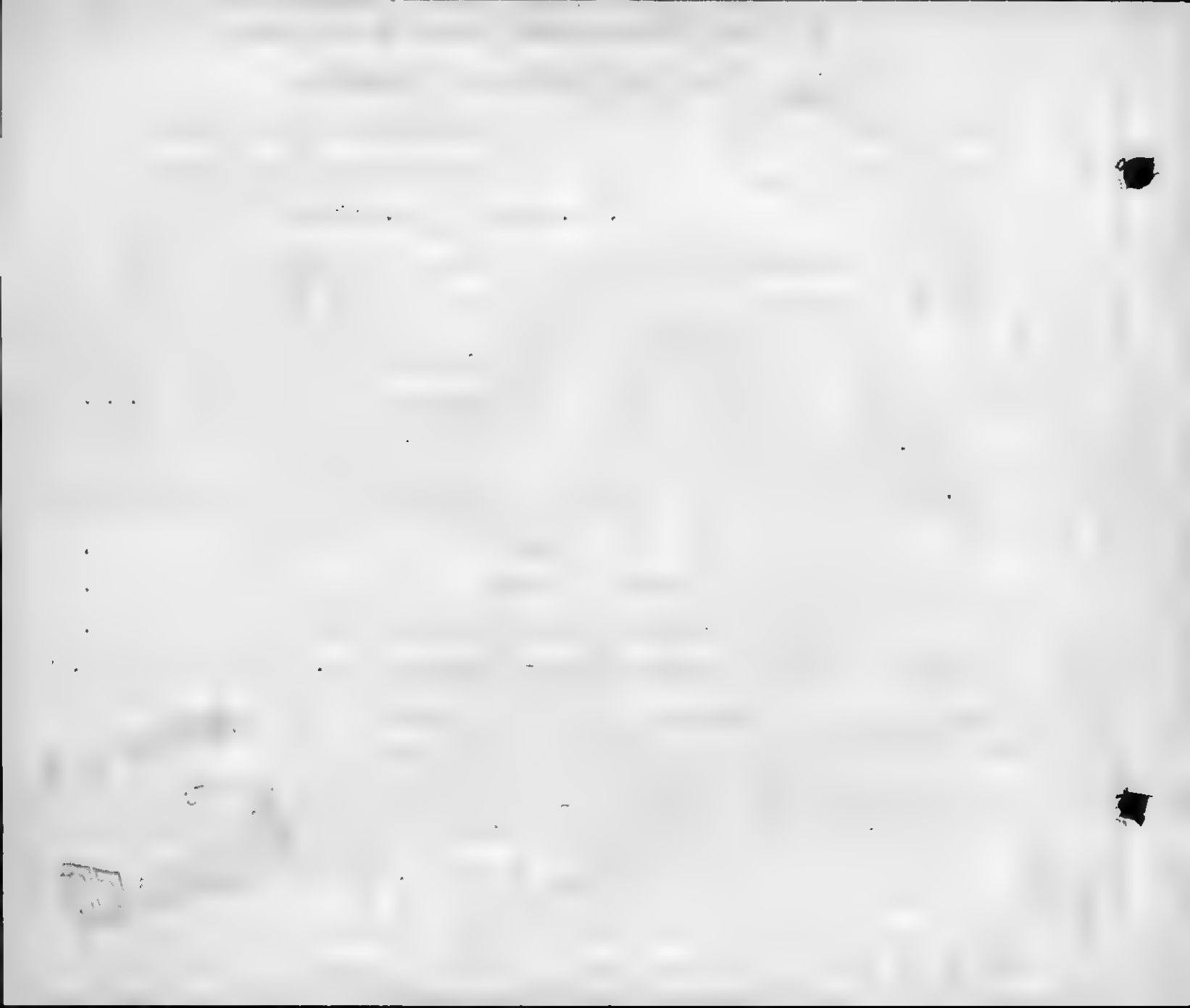
11800

11805

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Sykesville</u>		LENGTH OF STAY (In this place) <u>33yr. 6mo. 25days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainer</u>		<u>11 16.00</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>3210 upshur st</u>			
3. NAME OF DECEASED (Type or Print) <u>AMANDA</u> (First) <u>MILLER</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>19</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>March 27, 1885</u>		9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typist</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James W. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Sally Blair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital records</u>		
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						15. MEDICAL CERTIFICATION	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Acute edema of lung</u>						INTERVAL BETWEEN ONSET AND DEATH <u>hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Infarction</u>						<u>hrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerotic Heart Disease</u>						<u>yrs.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Dementia Praecox - hebephrenic type.</u>						<u>33 yr. +</u>	
19a. DATE OF OPERATION <u>2</u>			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>12-19</u>, 19 <u>55</u>, to <u>12-19</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>12-19</u>, 19 <u>55</u>, and that death occurred at <u>8:30P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12-20-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/22/55</u>		NAME OF CEMETERY, OR CREMATORY <u>Park Heights Cem Co</u>		LOCATION (City, town, or county) <u>Brunswick, Md</u>	
24. REC'D BY REGISTRAR <u>DEC 22 1955</u>		REGISTRAR'S SIGNATURE <u>Victor E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Sykesville Md</u>		ADDRESS	



11806

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>7 days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>3745 Beech Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SAMUEL</u> (Middle) <u>HULETT</u> (Last) <u>PENNINGTON</u>				(Month) <u>12</u> (Day) <u>27</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>10/15/96</u>	
9. AGE last birthday <u>59</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Months		Days		Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Lee R. Pennington</u>				14. MOTHER'S MAIDEN NAME <u>Laraine M. Hulett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>536-10-3093</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Irreversible Shock</u>						<u>hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>perforated gastric ulcer</u>						<u>1 day</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic brain syndrome with psychotic reaction due to cerebral arteriosclerosis</u>						<u>1 month</u>	
19a. DATE OF OPERATION <u>12/26/55</u>				19b. MAJOR FINDINGS OF OPERATION <u>Perforated gastric ulcer and bile peritonitis</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/26/55</u> , 19 <u>55</u> , to <u>12/27/</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>55</u> , and that death occurred at <u>10:30AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edward R. Adams, M.D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>12/29/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 29 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacoast</u> - ADDRESS <u>4600 Liberty Hgts. Ave.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be delivered for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

DEC

RECEIVED

11807

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Carroll</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Carroll</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Winfield</i>	LENGTH OF STAY (in this place) <i>Life</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Winfield</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Edgar E. Pickett</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Dec. 14 1955</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>Aug. 2, 1882</i>
9. AGE last birthday: <i>73</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>lumber maker</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Broom</i>	
11. BIRTHPLACE (State or foreign country): <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME: <i>Wm. W. Pickett</i>		14. MOTHER'S MAIDEN NAME: <i>Anna Haines</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>no</i>		16. SOCIAL SECURITY NO.: <i>none</i>	
17. INFORMANT & ADDRESS: <i>Mr. Bertha Pickett - Westminster Md.</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <i>154X</i>		<i>3+ Months</i>	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		<i>1+ years.</i>	
(A) <i>Generalized carcinomatosis</i>			
DUE TO			
(B) <i>adenocarcinoma of rectum</i>			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
		<i>Adenocarcinoma of rectum</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1954</i> , 19..., to <i>14 Dec., 1955</i> , that I last saw the deceased alive on <i>12 Dec., 1955</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>H. Lawson</i>		DATE SIGNED <i>14 Dec. 1955</i>	
M. D. <i>Dykesville - Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<i>Burial</i>		<i>12-16-55</i>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Cheney</i>		<i>Winfield, Carroll, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<i>Dec. 13, 1955</i>		<i>E. M. Farver</i>	
24. FUNERAL DIRECTOR		ADDRESS	
<i>Arthur H. Hargis</i>		<i>Dykesville, Md.</i>	

RECEIVED

DEC 28 1955

BUREAU V. S.

11808

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville, Maryland</u>		LENGTH OF STAY (in this place) <u>3yrs. 9mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>4114 Fernhill Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Emma Louise Pindell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 23 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-22-1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Ogdensburg, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Farley</u>				14. MOTHER'S MAIDEN NAME <u>Fanny Houniel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4. IMMEDIATE CAUSE (A) <u>Lobar pneumonia</u>				<u>24 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Chronic myocarditis</u>				<u>10 yrs.</u>			
(C) <u>Gen'l. arteriosclerosis</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-27</u>, 19<u>52</u>, to <u>12-21</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12-21</u>, 19<u>55</u>, and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. J. Weston M.D.</u>				ADDRESS (Street, city, town, state) <u>M.D. Springfield State Hosp. Sykesville, 12-23-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>C. H. H. H. H.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Weston</u>		ADDRESS <u>1217 St Paul St. Baltimore, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

DEC 23 1955

BUREAU V. B.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11809

CERTIFICATE OF DEATH

11804

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville</u>		LENGTH OF STAY (in this place) <u>3 mos. 29 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pasadena</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>Route 5 -- Box 205</u>			
3. NAME OF DECEASED (Type or Print) <u>Evelyn</u> (First) <u>Ridgely</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>14</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-17-1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pasadena, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Mumphrey Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Riggs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				ONSET AND DEATH <u>Suddenly</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-12-</u>, 19 <u>55</u>, to <u>12-13-</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>12-13-</u>, 19 <u>55</u>, and that death occurred at <u>4:00 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>M. N. Mastin, M.D.</u>				DATE SIGNED <u>12-14-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR			
25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter A. Hight, Sykesville, Md.</u>				26. ADDRESS <u>Walter A. Hight, Sykesville, Md.</u>			
DATE <u>Dec. 16, 1955</u>				REGISTRAR'S SIGNATURE <u>C. Harry Baker</u>			

BUREAU V. S.

DEC 20 19

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11806

11810

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Henryton</u>		<u>1 yr. 6 mos. 9 das.</u>		TOWN <u>Deanwood Park</u>		<u>16 X - 5</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Henryton State Hospital</u>				STREET ADDRESS (If rural give location) <u>1101 54th Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u> (Middle) <u>Robinson</u> (Last)				(Month) <u>12</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>Colored</u>		<u>Married</u>		<u>1-2-1892</u>	
						9. AGE last birthday	
						<u>63</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Work</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						<u>Greenwood, S. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Walter S. Robinson</u>				<u>Alice Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
(If Yes, give war or dates of service)				<u>Unknown</u>		<u>Deceased</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>IMMEDIATE CAUSE (A) <u>Heart Failure</u></u>							
<u>ANTECEDENT CAUSE(S) DUE TO (B) <u>Liver damage</u></u>							
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Pulmonary tuberculosis, far advanced</u></u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION							
19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	
						(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21h. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 7, 1954</u>, to <u>Dec. 16, 1955</u>, that I last saw the deceased alive on <u>Dec. 16, 1955</u>, and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>T. T. Nestor</u>				ADDRESS (Street, city, town, state) <u>Henryton, Md.</u>		DATE SIGNED <u>12-16-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
				<u>12/17/55</u>		<u>Washington</u>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE <u>12-16-55</u>				<u>Albert R. Sumpham</u>		<u>H. S. Washington</u>	
						<u>467 N. St. N.W.</u>	
						<u>Wash., D.C.</u>	

270

W. B. Washington 12-11-1871

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11771

CERTIFICATE OF DEATH

11807

Reg. Dist. No. 11807

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>CARROLL</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		LENGTH OF STAY (In this place) <u>62 YRS</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		<u>21</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>43 E. MAIN</u>				STREET ADDRESS (If rural give location) <u>43 E. MAIN</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>VOLA AGNES RUPPERT</u>				<u>DEC. 3 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATELY <u>MARRIED</u>		8. DATE OF BIRTH <u>JULY 28 1893</u>	
9. AGE last birthday <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RICHARD ARNOLD</u>				14. MOTHER'S MAIDEN NAME <u>LAURA TANNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-18-1372</u>		17. INFORMANT & ADDRESS <u>JOSEPH A. RUPPERT 43 E main Westminster Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
59'X IMMEDIATE CAUSE (A) <u>Chronic Vascular Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1945</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension & chronic</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Nephritis</u>				<u>10-15 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>U</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 3, 1940</u> to <u>Dec 3, 1955</u> that I last saw the deceased alive on <u>Dec 3, 1955</u> and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. B. Bannard</u>				ADDRESS (Street, city, town, state) <u>Westminster Md.</u>		DATE SIGNED <u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-7-1955</u>		NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMETERY</u>		LOCATION (City, town, or county) (State) <u>Westminster Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. B. Bannard</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. BANNARD & SON</u>		ADDRESS <u>WESTMINSTER MD.</u>	
DATE <u>12-7-55</u>							



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11808

11811

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County CARROLL Co.City or town GAMBER, MD.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CARROLLCity or town GAMBER, MD.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) if veteran, name war

3.(a) FULL NAME

JOHN WILBERT L. SCHARFE

3.(b) Social Security Number

9

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED6.(b) Name of husband or wife EMILY J. SCHARFE6.(c) If alive, give age 67 years7. Birth date of deceased (mo., day, yr.) JUNE 9, 18868. AGE: Years Months Days If less than one day
69 hrs. min.9. Birthplace MARYLAND.
(Town, county, and state)10. Usual occupation RETIRED MACHINIST11. Industry or business BLACK & DECKER12. Name HERMAN SCHARFE13. Birthplace MARYLAND.14. Maiden name ALICE H. SIPPLE15. Birthplace MARYLAND16. Informant EMILY J. SCHARFEAddress GAMBER, MD.17. Burial Date thereof Dec 26, 1955
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory PROVIDENCELocation GAMBER, MD.18. Funeral director Austin E. DonovanAddress 3818 Roland Ave,19. Dec. 24 19 55
(Date rec'd by registrar)R.W.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 23, 1955 at 7:05 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1955 to 23 Dec 1955and that I last saw him alive on 23 Dec 55Immediate cause of death Cardiac arrestBronchial pneumoniaAsplenia, arteriosclerotic heartDue to Swiss

Due to

Other conditions

Major findings of operations

Date of op.

Autopsy results

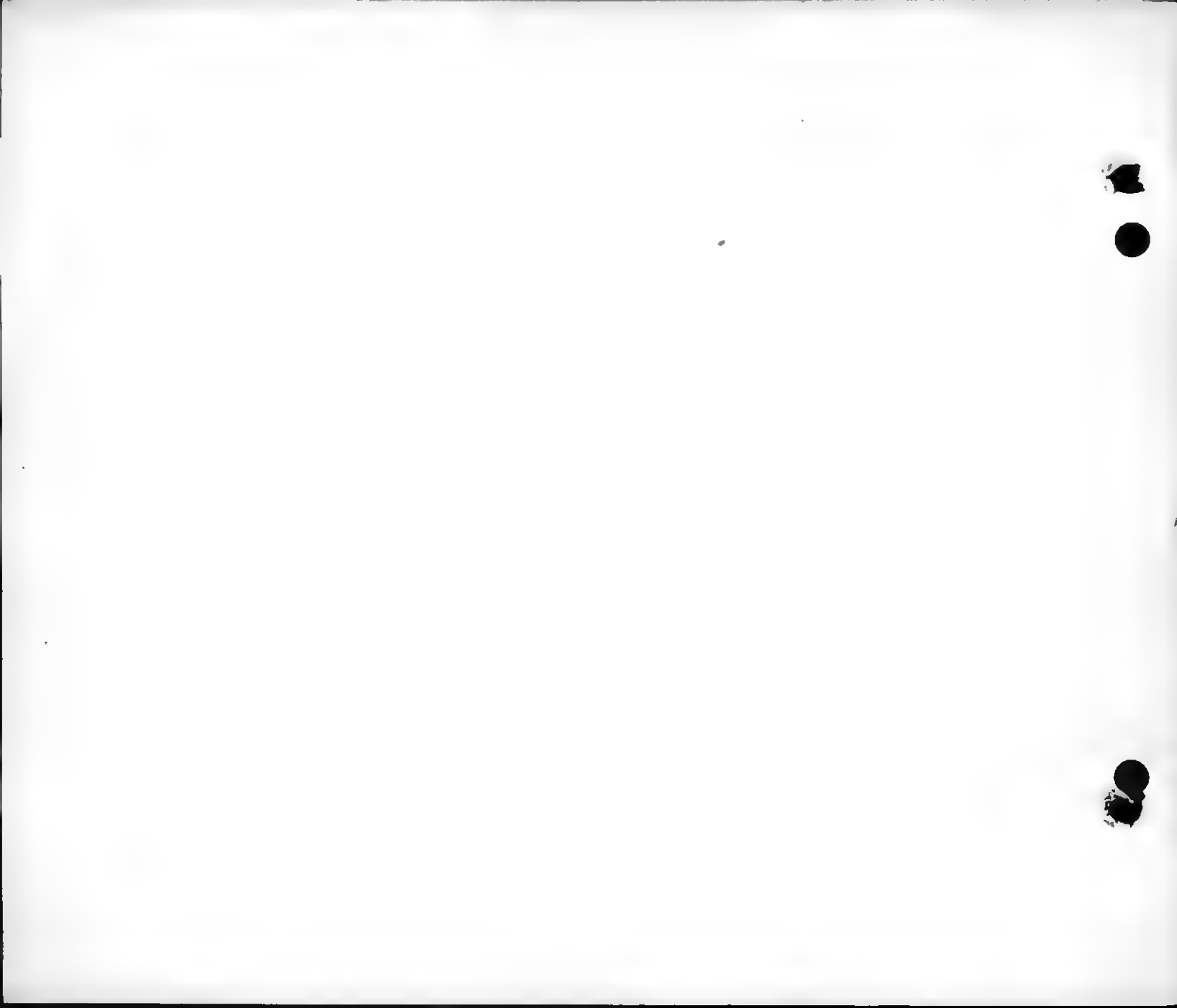
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date ofWhere did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard E. Hall
M. D. or other
Address Sherrille, Ind Date signed 23 Dec 55



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

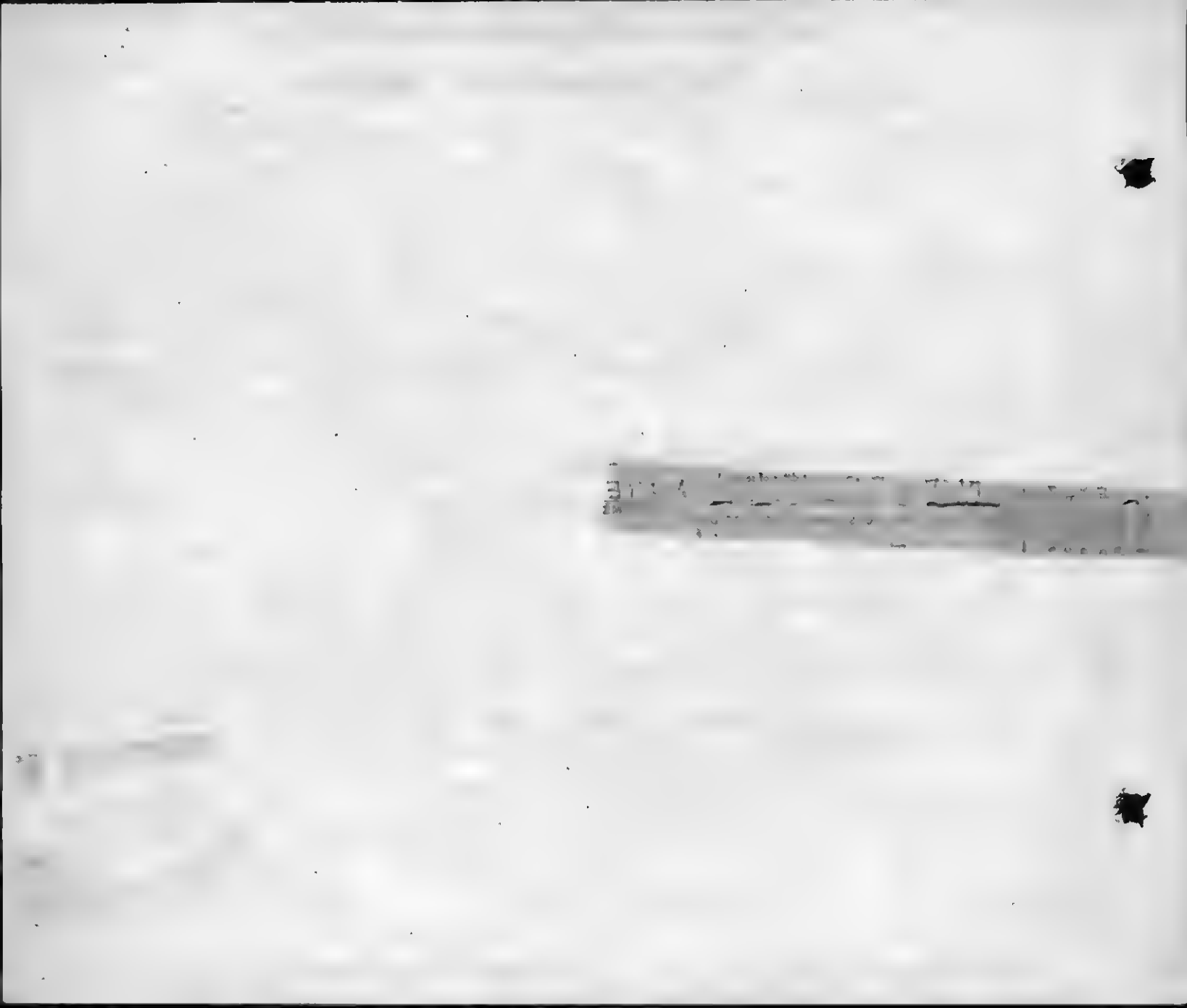
11809

11812

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>RURAL WESTMINSTER</u>		<u>80 yrs.</u>		TOWN <u>RURAL WESTMINSTER</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. 6</u>				STREET ADDRESS (If rural give location) <u>R.D. 6</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>FRANK ALBERT SCHERER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12-12-1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>6-2-1870</u>	9. AGE last birthday <u>85</u> yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>			10b. KIND OF BUSINESS <input type="checkbox"/> INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL SCHERER</u>				14. MOTHER'S MAIDEN NAME <u>AMELIA WHITLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or both.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>5-27 E. CHURCH ST. ELLA Z. FAHINNEY-FREDERICK, MD.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>Five months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiac</u>						<u>10 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Renal Disease</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 10, 1955</u> to <u>Dec 12, 1955</u> , that I last saw the deceased alive on <u>Dec 12, 1955</u> , and that death occurred at <u>5:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William Pericles</u> M.D.				ADDRESS (Street, city, town, state) <u>Westminster, Md.</u>			
DATE SIGNED <u>12-12-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-14-1955</u>		NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		LOCATION (City, town, or county) (State) <u>FREDERICK MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
				<u>Al Bunkard</u>		<u>Westminster, Md.</u>	



1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

11813

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Md</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>10 mo</u>		TOWN <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2307 Aisquith St.</u> ✓			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>James Thomas Schiller</u>				<u>Dec. 17 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	INTERVAL BETWEEN ONSET AND DEATH		
<u>M</u>	<u>W</u>	<u>wid.</u>	<u>Nov. 1863</u>	<u>92</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>store owner</u>		<u>cigar store</u>		<u>Wilmington Delaware, U.S.A.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Jacob Schiller</u>				<u>Margaret Dunbar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>unk</u>		<u>220-07-70124</u>		<u>Records of Springfield State Hosp.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>generalized arteriosclerosis</u>						<u>more than 10 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>psychosis with senile brain disease</u>						<u>more than 10 mo</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 2, 1955, to Dec. 17, 1955, that I last saw the deceased alive on Dec. 17, 1955, and that death occurred at 10:48 M. from the causes and on the date stated above.							
SIGNATURE <u>Martin Gross, M.D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Md.</u>		DATE SIGNED <u>Dec. 18, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-21-55</u>		<u>Overbrook</u>		<u>Brighton, N. J.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec. 18, 1955</u>		<u>C. Henry Wier</u>		<u>H. G. ...</u>		<u>North ...</u>	

U. S. A.

DEC

REG 2004-11-11

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11811

11814

CERTIFICATE OF DEATH

Reg. Dist. No.

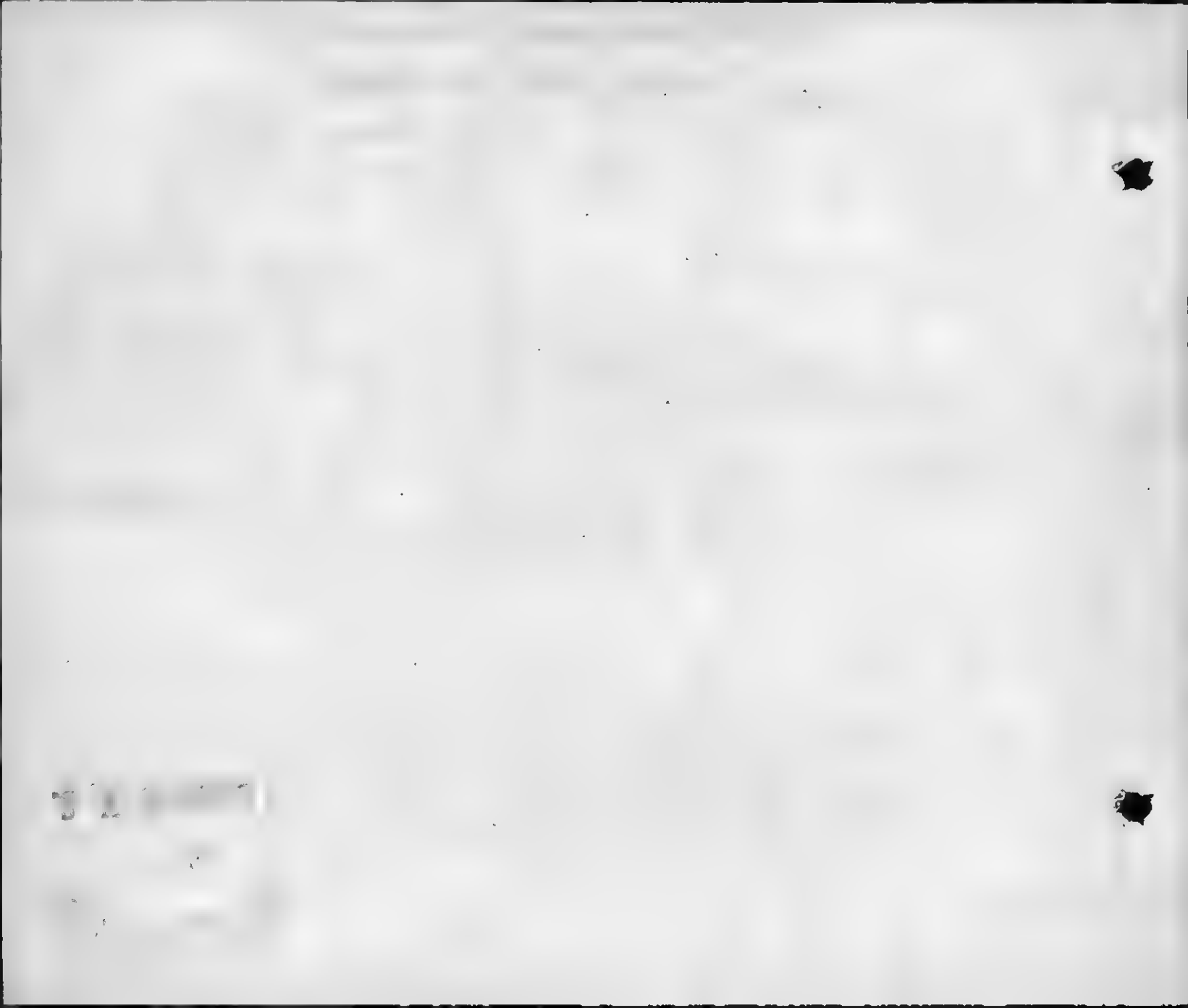
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN		TOWN	
X TOWN <u>Rural - Sykesville</u>		<u>5Y, 1M, 12 days</u>		<u>Baltimore</u>		<u>3431 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>301 South Monroe Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Albert George SEITLER</u>				<u>12 1 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
<u>Male</u>	<u>W</u>	<u>single</u>	<u>12/9/04</u>	<u>50</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Helper in shipping dept.</u>		<u>utilities</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Leo Seidler</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Cromwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>unknown</u>				<u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
154X IMMEDIATE CAUSE (A) <u>Carcinoma of rectum with metastases to liver</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <u>Colostomy performed</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Involuntal psychotic reaction</u>						2 weeks 5 years +	
19a. DATE OF OPERATION <u>11/15/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Parent lesion in rectum; liver studded with CA</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/20</u> , 19 <u>55</u> , to <u>12/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>55</u> , and that death occurred at <u>8:10AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Springfield</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville Maryland</u>		DATE SIGNED <u>12/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		LOCATION (City, town, or county) (State) <u>Greenwood</u>	
24. REC'D BY REGISTRAR <u>DEU</u>		REGISTRAR'S SIGNATURE <u>C. Harry Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Sney</u>		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11815

CERTIFICATE OF DEATH

12556

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>M.D.</u> COUNTY <u>CARROLL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HAMPSTEAD</u>		STREET ADDRESS (If rural give location) <u>R.D. 1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HAMPSTEAD</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HAMPSTEAD</u>		STREET ADDRESS (If rural give location) <u>R.D. 1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. 1</u>							
3. NAME OF DECEASED (Type or Print) <u>MURRAY RITTER SLAGLE</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>7-7-1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RUR. FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARTIN L. SLAGLE</u>				14. MOTHER'S MAIDEN NAME <u>not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-20-18-1593</u>		17. INFORMANT & ADDRESS <u>Martin L. Slogh R.D. 1 Hampstead, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Arterio-sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Old Coronary Thrombosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 1955</u> to <u>Dec 20, 1955</u> , that I last saw the deceased alive on <u>Dec 20, 1955</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M.C. Porter</u>				ADDRESS (Street, city, town, state) <u>Hampstead, Md.</u>		DATE/SIGNED <u>12-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-31-1955</u>		NAME OF CEMETERY OR CREMATORY <u>KRIDERS GEM.</u>		LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Hunt</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bankard</u>		ADDRESS <u>Westminster, Md.</u>	
DATE <u>1-2-56</u>							



INSTRUCTIONS
PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

11816

CERTIFICATE OF DEATH

11812

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>---</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Rural - Sykesville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
TOWN <u>Springfield State Hospital</u>				TOWN <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>19 E. Centre Street, Baltimore-2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>George</u> (Middle) <u>Washington</u> (Last) <u>SPANGLE</u>				(Month) <u>12</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>July 9, 1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>printer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>printing</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
13. FATHER'S NAME <u>James Spangle</u>				14. MOTHER'S MAIDEN NAME <u>unknown to us</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Records of Springfield State Hospital</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>260X</u> IMMEDIATE CAUSE (A) <u>CEREBRAL ARTERIO SCLEROSIS ENCEPHALOMALACIA DUE TO ARTERIO SCLEROSIS</u>				<u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>R. HEMIPLEGIA.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>DIABETES.</u>				<u>years</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CHRONIC BRAIN SYNDROME ASSOCIATED WITH ARTERIO SCLEROSIS</u>				<u>years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 28th, 1955, to December 3, 1955, that I last saw the deceased alive on 12-3, 1955, and that death occurred at 11 A.M. from the causes and on the date stated above.							
SIGNATURE <u>Edw. Radzyrewski</u> M.D.				DATE SIGNED <u>12/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>removal</u>				24. REC'D BY REGISTRAR			
DATE THEREOF <u>12/6/55</u>				REGISTRAR'S SIGNATURE <u>C. Harry Hays</u>			
NAME OF CEMETERY OR CREMATORY <u>Coalport</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. ...</u>			
LOCATION (City, town, or county) <u>Coalport, Pennsylvania</u>				ADDRESS <u>1217 St. Paul Street</u>			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11813

11817 CERTIFICATE OF DEATH

Items 10a, 11, 13, 14 Film G190 12-23-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural - Sykesville</u>		<u>11 days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>421 West 24th Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CHARLES</u> (Middle) <u>MILTON</u> (Last) <u>SPRING</u>				(Month) <u>12/</u> (Day) <u>13</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>		<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Watchman</u>				<u>Maryland</u>		<u>U.S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>24 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>						<u>several years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/2</u> , 19 <u>55</u> , to <u>12/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>55</u> , and that death occurred at <u>9:25 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Sonnenfeldt</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>12/16/55</u>		<u>Baltimore</u>		<u>E. North Ave.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>C. Harry Kees</u>		<u>Paul E. Schenck</u>		<u>3615-17 Schenck</u>	
DATE							

MB

S. A. 1000

11814

MARYLAND STATE DEPARTMENT OF HEALTH

11818

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERSReg. Dist. No. 70

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Pratt</u> TOWN <u>Pratt</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pratt</u>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pratt</u> TOWN <u>Pratt</u> STREET ADDRESS (If rural, give location) <u>Pratt</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>ELMER</u>		(Middle) <u>KEFAUER</u>		(Last) <u>STANBACH</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>1-1-1914</u>	9. AGE last birthday <u>41</u> yrs.	If under 1 year Months Days Hours Min.		1955
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm H. Stanbach</u>				14. MOTHER'S MAIDEN NAME <u>Martha Stanbach</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-12-1464</u>		17. INFORMANT <u>Dr. J. M. Marsh</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Gunshot wound of abdomen</u>						<u>Minutes</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u> (CITY OR TOWN) <u>Pratt</u> (COUNTY) <u>Carroll</u> (STATE) <u>MD</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12 12 55 10P</u> m.				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Shot with shot gun</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <u>J. M. Marsh</u> (Degree or title) <u>Deputy Medical Examiner</u>				DATE SIGNED <u>12/13/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>12-13-55</u>		NAME OF CEMETERY OR CREMATORY <u>Pratt</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>Dec 14/55</u>		REGISTRAR'S SIGNATURE <u>Ethel M. McHugh</u>		24. FUNERAL DIRECTOR <u>Pratt</u>		ADDRESS <u>Pratt</u>	



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10-1-10
10-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11815

11819

71

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frizzleburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frizzleburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Margaret</u> <u>Savilla</u> <u>Stevenson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec.</u> <u>9</u> , 19 <u>55</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>July 13, 1882</u>
9. AGE last birthday <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus Utermahlen</u>		14. MOTHER'S MAIDEN NAME <u>Annie Wantz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr.s Louise Nygren, Frizzleburg, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> <u>4 yrs</u>
Immediate cause (a) <u>Acute cardiac dilatation</u>		
Antecedent cause(s) (b) <u>Cardio Renal Vascular Disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1951, to Dec 9, 1955, that I last saw the deceased alive on Dec 8, 1955, and that death occurred at 5:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Chas. R. Foutz, M.D., Westminster, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Dec. 11, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cemetery</u>	LOCATION (City, town, or county) (State) <u>Pleasant Valley, Maryland</u>
DATE REC'D BY LOCAL REG. <u>12/16</u>	REGISTRAR'S SIGNATURE <u>Margaret R. Englar</u>	24. FUNERAL DIRECTOR <u>C.O. Fuss & Son, Taneytown, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11816

11820

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Carroll</i>			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Rural, Westminster</i>		<i>5 yrs.</i>		TOWN <i>Rural, Westminster RD #5</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Westminster RD #5</i>				STREET ADDRESS (If rural give location) <i>Spring milk</i>			
3. NAME OF DECEASED (Type or Print) <i>MARY ETTHA STEVENSON</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Dec-31-1955</i>			
5. SEX <i>f.</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify if married) <i>married</i>	8. DATE OF BIRTH <i>Oct-4-1877</i>	9. AGE last birthday <i>78</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>London Co., Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Jesse Stevenson</i>				14. MOTHER'S MAIDEN NAME <i>Mary Triplett</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Westminster Md #5</i> <i>Mr. John E. Stevenson</i>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>							
ANTECEDENT CAUSE(S) DUE TO <i>Hypertension</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <i>Myocarditis (Chc)</i>							
STATING UNDERLYING CAUSE LAST (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.			21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Jan 20</i> , 19 <i>50</i> , to <i>Dec 31</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Dec 30</i> , 19 <i>55</i> , and that death occurred at <i>3 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>W. C. Jeonette</i>				ADDRESS (Street, city, town, state) <i>103 N Main Westminster Md</i>			
				DATE SIGNED <i>12-31-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan 3-1956</i>		NAME OF CEMETERY OR CREMATORY <i>Pruders Cemetery</i>		LOCATION (City, town, or county) (State) <i>Rural, Westminster Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Harriet Miller</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers Jr</i>		ADDRESS <i>Westminster Md</i>	
DATE <i>Jan 1, 1956</i>							

EDWARDS

JAN 4 1

11821

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
CITY OR TOWN <u>UNION BRIDGE</u>		LENGTH OF STAY (in this place) <u>years</u>		STREET ADDRESS <u>STONER ST.</u>		STREET ADDRESS (If rural give location) <u>STONER ST.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JOHN W STRAWSBURG</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 16 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>AUG 8-1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LEIGHT CO</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POWER HOUSE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN W STRAWSBURG</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HARRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-09-0211</u>		17. INFORMANT & ADDRESS <u>CAROLINE STRAWSBURG UNION BRIDGE</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
597x IMMEDIATE CAUSE (A) <u>CHRONIC NEPHRITIS</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>HIGH BLOOD PRESSURE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12-16-55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>12-16-55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>Dec 16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-16-</u> , 19 <u>55</u> , and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>T. H. L. EGG</u> M.D.				ADDRESS (Street, city, town, state) <u>Union Bridge</u>		DATE SIGNED <u>12-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/18/55</u>		NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>		LOCATION (City, town, or county) (State) <u>UNIONTOWN MD</u>	
24. REC'D BY REGISTRAR <u>12/17/55</u>		REGISTRAR'S SIGNATURE <u>Leslie L. Reppe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>DDHARTZLER & SONS</u>		ADDRESS <u>UNION BRIDGE</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. The first part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

2. The second part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

3. The third part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

4. The fourth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

5. The fifth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

6. The sixth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

7. The seventh part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

8. The eighth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

9. The ninth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

10. The tenth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.



100

11818

MARYLAND STATE DEPARTMENT OF HEALTH

11822

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 77

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>—</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hampstead</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>1921 Linden Ave 361-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		STREET ADDRESS <u>Baltimore</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Edith</u> (Middle) <u>Brown</u> (Last) <u>Towney</u>		4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7/16/1913</u>
9. AGE last birthday <u>42</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Wesley Brown</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Lee Henryman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT <u>Mason Curtis-Reisterstown Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

981X Immediate cause

(a)

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

(d)

(e)

(f)

(g)

(h)

(i)

(j)

(k)

(l)

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BUREAU V. S.

DEC 12 1975

RECEIVED

11819

MARYLAND STATE DEPARTMENT OF HEALTH

11823

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 77

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hampstead</u> LENGTH OF STAY (in this place) <u>3 hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> <u>3Y 1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>2117 Bolton St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Paul</u> (Middle) <u>Horner</u> (Last) <u>Taylor</u>	4. DATE OF DEATH	(Month) <u>Dec</u> (Day) <u>5</u> (Year) <u>1955</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 10 - 1901</u> 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>John Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Mae Wildasin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>180-01-9909</u>	17. INFORMANT <u>Jacob Harkentine, New Freedom Pa</u>
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>776X Shot gun Wound</u>			<u>None</u> <u>(Instant)</u>
Antecedent cause(s) <u>of head (Suicide)</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office, etc.) INJURY <u>gun</u>	(CITY OR TOWN) <u>Hampstead</u> (COUNTY) <u>Carroll</u> (STATE) <u>MD</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>December 5, 1955</u> m. <u>2:50 PM</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Self inflicted</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>W. H. F. Oard</u>		DATE SIGNED <u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12-5-55</u>	NAME OF CEMETERY OR CREMATORY <u>Mid Line Cemetery</u>
DATE REC'D BY LOCAL REG. <u>12/5/55</u>		REGISTRAR'S SIGNATURE <u>Henry H. H. H.</u>	24. FUNERAL DIRECTOR <u>Edw. Chilton, Hampstead</u>
		ADDRESS <u>MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 12 1955

U. S. BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11820

11824

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Mt. Airy</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt. Airy</u>	
TOWN <u>Parrsville</u>		TOWN <u>Parrsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Parrsville</u>		STREET ADDRESS <u>Route 4</u> (If rural, give location)	
3. NAME OF DECEASED (First) <u>Joanne</u> (Middle) <u>-</u> (Last) <u>Thomas</u>		4. DATE OF DEATH (Month) <u>December</u> (Day) <u>20</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>-</u>	8. DATE OF BIRTH <u>Aug. 6, 1955</u>
9. AGE last birthday <u>4</u> yrs. <u>4</u> months <u>14</u> days		10. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Melvin Dewitt Myers</u>		14. MOTHER'S MAIDEN NAME <u>Ada Mae Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Ada Mae Thomas, Mt. Airy, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Acute Gastro enteritis of Undetermined etiology</u>		<u>4 days</u>
Antecedent cause(s) (b) <u>-</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>-</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December 17, 1955, to December 19, 1955, that I last saw the deceased alive on Dec. 19, 1955, and that death occurred at 8:45 P. M., from the causes and on the date stated above.

SIGNATURE W. B. Culwell M.D. (Degree or title) ADDRESS Mt. Airy, Md. DATE SIGNED Dec. 20, 1955

23. BURIAL, CREMATION REMOVAL (Specify) <u>Interment</u>	DATE <u>12-22-1955</u>	NAME OF CEMETERY OR CREMATORIAL <u>Simpson Chapel</u>	LOCATION (City, town, or county) (State) <u>Howard Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>Dec. 22, 1955</u>	REGISTRAR'S SIGNATURE <u>Robert R. Hewitt</u>	24. FUNERAL DIRECTOR <u>So. M. Waltz</u>	ADDRESS <u>Winfield, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11825

CERTIFICATE OF DEATH

Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Canoll</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Canoll</u>
CITY (If outside corporate limits, write RURAL OR and give street town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL or TOWN)	(If rural give location)
TOWN <u>Fineboro</u>	<u>33 yrs</u>	TOWN <u>Fineboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
<u>Fineboro</u>		<u>Fineboro</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>CLARA SUSAN TRACY</u>		<u>Dec 21 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>June 28 1879</u>
9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>76 yrs.</u>	Months Days Hours Min.		
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>	<u>Lg</u>	<u>md</u>	<u>USA</u>
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:		
<u>Henry J. Steiner</u>	<u>Susana Steiner</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:	
<u>No</u>	<u>219-05-6467A</u>	<u>A. Parker Tracy Fineboro, md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
(a) Immediate cause			<u>2 yrs</u>
(b) Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.			<u>1 Mon</u>
(c) Congestive Heart Failure			<u>2 wks</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:			19b. MAJOR FINDINGS OF OPERATION
20. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work Not While At Work	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>aut 25</u> , 19 <u>55</u> , to <u>Dec 21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>55</u> , and that death occurred at <u>6:10 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>W. H. Hoand</u>		DATE SIGNED <u>12/21/1955</u>	
(Degree or title) <u>M.D.</u>		ADDRESS <u>Manchester, Md</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12/24/55</u>	<u>Lynchwood Cemetery</u>	<u>Fineboro, Canoll, Md</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>Dec 22-55</u>	<u>Mrs. N. P. Deener</u>	<u>H. K. G. Co. Glen Rock, Pa.</u>	

RECEIVED

EC 1955

BUREAU V. 3

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11822

11826

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u> COUNTY <u>-----</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>since 8-30-26</u>		CITY OR TOWN <u>Baltimore City</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS <u>unknown</u>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Justi</u> (Middle) <u>-</u> (Last) <u>TUHOMEN</u>				(Month) <u>December</u> (Day) <u>3</u> (Year) <u>19 55</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widower</u>		8. DATE OF BIRTH <u>unknown</u>	
9. AGE last birthday <u>64 ?</u>		10. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Finland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Finland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Finland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Finland</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Ida Tuhomen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Records of Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Lobar pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>-----</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>-----</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Hebephrenic schizophrenia</u>				<u>more than 29 yrs.</u>			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>-----</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>-----</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>-----</u> (County) <u>-----</u> (State) <u>-----</u>			
21d. TIME OF INJURY (Month) <u>---</u> (Day) <u>---</u> (Year) <u>---</u> (Hour) <u>---</u> (Min.) <u>---</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-----</u>			
22. I hereby certify that I attended the deceased from <u>Sept. 1st, 19 47</u> , to <u>Dec. 2nd, 19 55</u> , that I last saw the deceased alive on <u>Dec. 2nd 19 55</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. D. Martin Gross</u>				ADDRESS (Street, city, town, state) <u>M. D. Sykesville, Md.</u>		DATE SIGNED <u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u>		DATE THEREOF <u>DEC 6 1955</u>		NAME OF CEMETERY OR CREMATORY <u>U of M. MED SCHOOL</u>		LOCATION (City, town, or county) <u>GREEN ST.</u>	
24. RECEIVED BY REGISTRAR <u>C. Harry Thur</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Diffel Bros</u>		ADDRESS <u>1800 E LOAN BARR ST</u>	
DATE <u>Dec. 8, 1953</u>							

U.S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH

11823

11827

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERSReg. Dist. No. *Ed*

1. PLACE OF DEATH- COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>New Windsor Rural</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>New Windsor Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>PAUL BROWN WAGNER</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Dec 25 1955</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i>	8. DATE OF BIRTH <i>Dec 1-1893</i>
9. AGE last birthday <i>62</i> yrs.		10. If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Produce Dealer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retail</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jonas M. Wagner</i>		14. MOTHER'S MAIDEN NAME <i>Etta Brown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY No. <i>none</i>	
17. INFORMANT AND ADDRESS <i>Mrs. Norman Condou New Windsor Rural</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Asphyxiation - Asphyxiated fig.</i>			<i>minutes</i>
Antecedent cause(s) (b) <i>Hypertension Arteriosclerosis C.V. disease</i>			<i>year</i>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>12 25 J-1-10 A.M.</i>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <i>Asphyxiated fig.</i>			
22. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.			
SIGNATURE <i>James J. Phares</i>		DATE SIGNED <i>12/28/55</i>	
(Degree or title) <i>Deputy Medical Examiner</i>		ADDRESS <i>Wheaton Md</i>	
23. SPECIAL CREMATION (Specify) <i>Burial</i>		DATE THEREOF <i>12 28/55</i>	
NAME OF CEMETERY OR CREMATORY <i>Pipe Creek</i>		LOCATION (City, town, or county) (State) <i>Carroll Md</i>	
24. FUNERAL DIRECTOR <i>Wm. F. Hartman & Sons - New Windsor, Md</i>		ADDRESS	
DATE REC'D BY LOCAL REG. <i>Dec 28</i>		REGISTERAR'S SIGNATURE <i>Ernest S. Bonded</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EDWARD V. S.

DEC 1957

1957

11772 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Westminster</u>		<u>6 years</u>		TOWN <u>Westminster</u>		<u>27</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Carroll County Home</u>				STREET ADDRESS (If rural give location) <u>Carroll Co. Home</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Marshall</u> <u>Wetzel</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 5</u> <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Mar. 1, 1875</u>	
9. AGE last birthday <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Herzekiah Wetzel</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Oliver Fleming Woodbury</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
18a. IMMEDIATE CAUSE (A) <u>Exhaustion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Progressive</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arterio sclerosis</u>				<u>many yrs</u>			
(C) <u>?</u>							
18b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>He had gangrene in foot</u>				<u>1 mo.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>X</u>		<u>X</u>		<u>X</u>			
22. I hereby certify that I attended the deceased from <u>10-8-55</u>, to <u>12-5-55</u>, that I last saw the deceased alive on <u>12-4-55</u>, 19<u>55</u>, and that death occurred at <u>2:15 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. C. Stone</u>				ADDRESS (Street, city, town, state) <u>Westminster, MD</u>			
DATE THEREOF <u>12-8-55</u>				DATE SIGNED <u>12-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Brandenburg</u>		LOCATION (City, town, or county) (State) <u>Berrett, Carroll, MD</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Haight</u>			
DATE <u>12-5-55</u>				ADDRESS <u>Hypherville, MD</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completed by the funeral director, the third copy of this death certificate assembly should be detected for use as a burial transit permit.

VS A15C 1-55 10M

DEC 12

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11828

CERTIFICATE OF DEATH

11825

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Rural - Sykesville</u>		<u>1 mo. 29 days</u>		OR TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>10000 Markham Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Anna Elnore WIBLITZHouser</u>				<u>12 13 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>12/24/89</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Joseph Dalton</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Dalton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>74-24</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>						<u>years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>						<u>8 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/7/11</u>, 19 <u>55</u> ., to <u>12/13</u>, 19 <u>55</u> ., that I last saw the deceased alive on <u>12/12</u>, 19 <u>55</u> ., and that death occurred at <u>4:00A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>12/15/55</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		LOCATION (City, town, or county) <u>Arlington Va</u>		(State)	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Cunningham</u>		ADDRESS <u>8434 Sa Ave</u>		
DATE <u>Dec 13 1955</u>	<u>Sil Sp.</u>						

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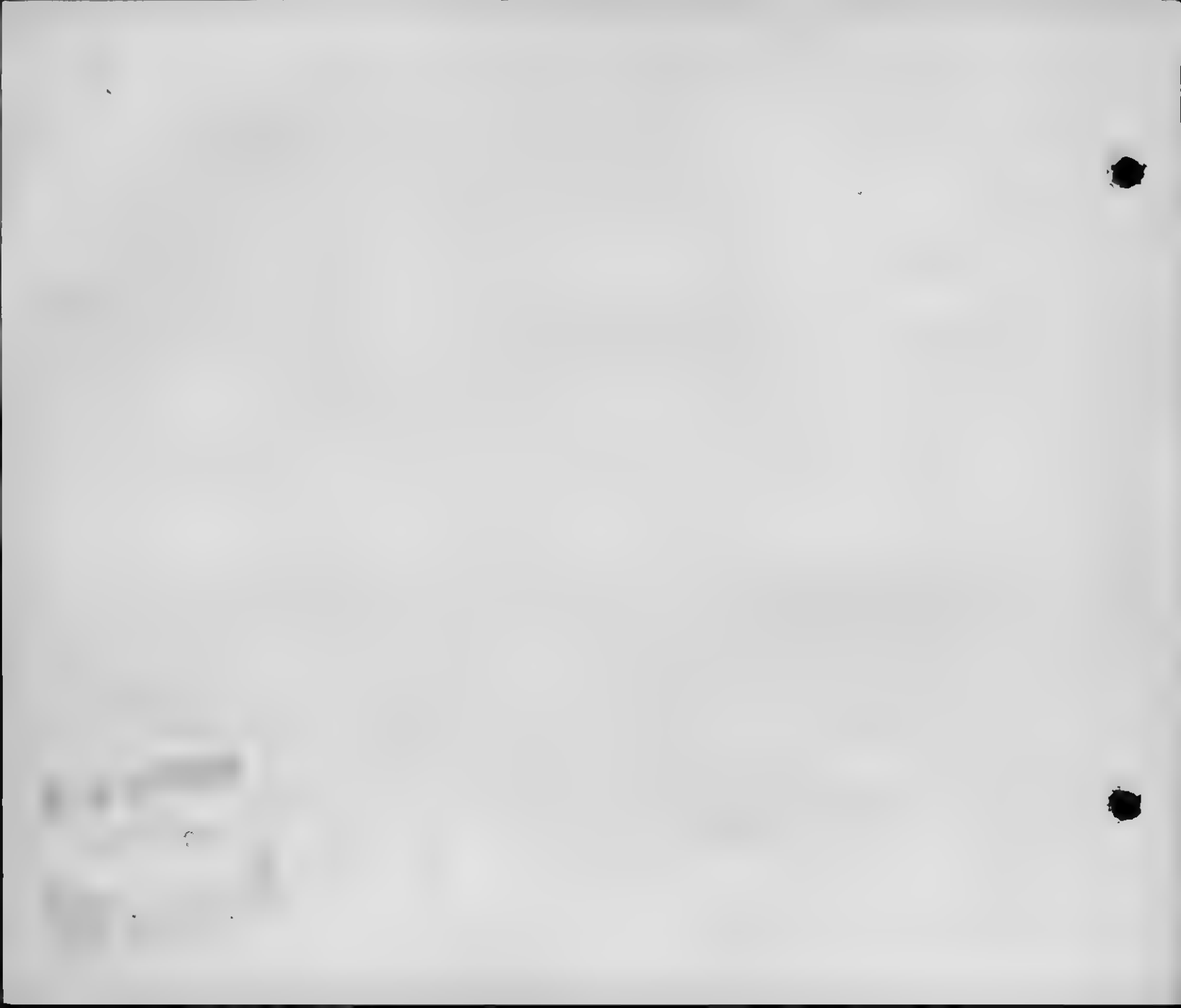
11829
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dis. 11826
No. 82/83

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Carroll		MARYLAND		STATE Maryland COUNTY Carroll			
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN rural--Mt. Airy		LENGTH OF STAY (in this place) 8 mo.		CITY (If outside corporate limits write RURAL and give nearest town) TOWN rural--Mt. Airy		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 47				STREET ADDRESS (If rural, give location) Mt. Olive			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) BENJAMIN N. WINES				4. DATE OF DEATH (Month) (Day) (Year) DEC. 11, 19 55			
5. SEX: male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH: 1875 ?	
				9. AGE last birthday: 80 2 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Chair maker		10b. KIND OF BUSINESS OR INDUSTRY: self-employ		11. BIRTHPLACE (State or foreign country): Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Elias Wines				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: none		17. INFORMANT & ADDRESS: Mrs. Fannie Tinsman, Mt. Airy, Md.			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH 7 hours. Several yrs.	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate cause (a) <i>Coronary Arteriosclerosis</i></p> <p>Antecedent cause(s) (b) <i>Arterio Sclerosis</i></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p> </div> <div style="width: 35%;"> <p>DUE TO</p> <p>DUE TO</p> </div> </div>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <i>James J. Wines</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> 12/11/55							
23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL		DATE THEREOF 12-14-1955		NAME OF CEMETERY OR CREMATORY Greenhill		LOCATION (City, town, or county) (State) Berryville, Va.	
DATE REC'D BY LOCAL REG. Dec. 13, 1955		REGISTRAR'S SIGNATURE <i>Robert B. Hewitt</i>		24. FUNERAL DIRECTOR <i>Wm. G. Wertz</i>		ADDRESS <i>Winfield, Md.</i>	

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 14 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ATSC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11827

11830

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>MARYLAND</u>		COUNTY <u>CARROLL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		LENGTH OF STAY (in this place) <u>YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BENEDUM ST.</u>				STREET ADDRESS (If rural give location) <u>BENEDUM ST.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>M. ANNIE YINGWING</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 27 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>OCT. 24-1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ELI HANN</u>				14. MOTHER'S MAIDEN NAME <u>DEBORAH STEM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>UNION MRS. WILBUR FOWBLE BRIDGE, MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
a. IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>							
b. ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
c. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>3</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 23 1955</u> to <u>Dec 27 1955</u> , that I last saw the deceased alive on <u>Dec 26, 1955</u> and that death occurred at <u>12:30</u> from the causes and on the date stated above.							
SIGNATURE <u>J. W. Legg M.D.</u>				ADDRESS (Street, city, town, state) <u>Union Bridge, MD</u>		DATE SIGNED <u>12-28-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>DEC 30-55</u>		NAME OF CEMETERY OR CREMATORY <u>MT. VIEW CEM.</u>		LOCATION (City, town, or county) (State) <u>UNION BRIDGE, MD</u>	
24. REC'D BY REGISTRAR <u>See 1/9/56</u>		REGISTRAR'S SIGNATURE <u>L. P. P.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D. HARTZLER & SONS</u>			
DATE <u>See 1/9/56</u>				ADDRESS <u>UNION BRIDGE, MD</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11831

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 11828

No. 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Sykesville Md.</u>		<u>29 yrs</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hosp.</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) <u>Bertie</u> (Middle) <u>S.</u> (Last) <u>Youngman</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>10</u> (Year) <u>19 55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>	8. DATE OF BIRTH: <u>?</u>	9. AGE last birthday: <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Youngman</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Russell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>917.7</u> Immediate cause (a) <u>Acute Shock</u> DUE TO <u>Extensive scalding of the body by hot water</u>						<u>Min.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) <u>Diabetes</u> DUE TO							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Schizophrenic Reaction paranoid type</u>						<u>L.</u>	
18a. DATE OF OPERATION:		18b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>hospital</u>		21c. (City or town) (County) (State) <u>Sykesville Carroll Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec 10 1955 2 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Burned by hot water in tub</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>James J. Shaver</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/10/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12-13-55</u>		NAME OF CEMETERY OR CREMATORY <u>Bowdon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 11, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Green</u>		24. FUNERAL DIRECTOR ADDRESS <u>J. O. Mitchell & Sons - 1900 Eastway Hwy. Balt.</u>			

EDWARD V. S.

DEC 10 1900

EDWARD V. S.

MARYLAND

11832

11829
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

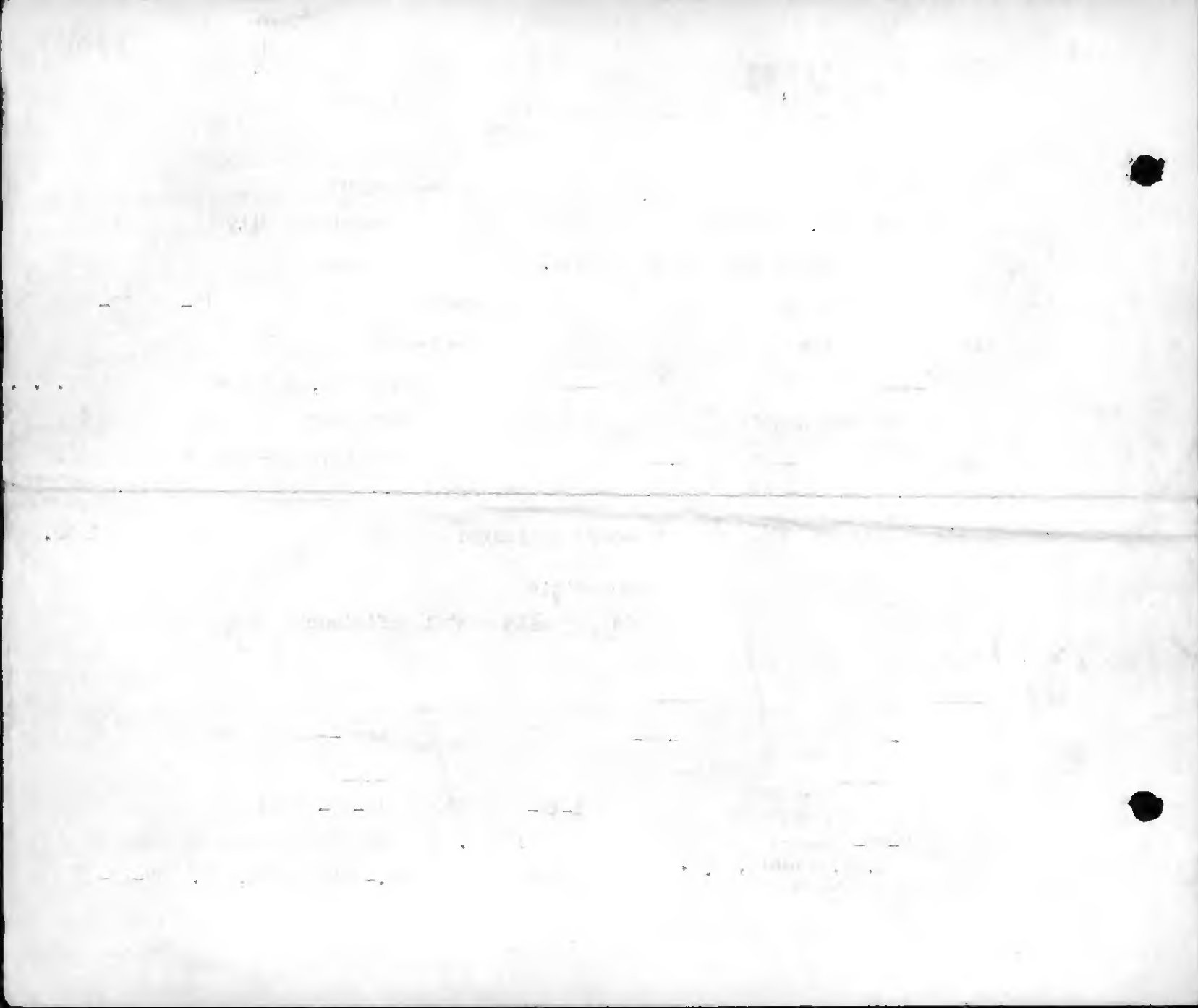
1. PLACE OF DEATH COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sykesville, Maryland		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) Alois (Middle) (Last) Zephir	4. DATE OF DEATH (Month) 12- (Day) 27- (Year) 1955		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 3-26-1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 52 yrs. If under 1 year If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Zephir		14. MOTHER'S MAIDEN NAME Dora Zang	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT AND ADDRESS Hospital records	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Coronary occlusion			1 hr.
Antecedent cause(s) (b) Myocarditis			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Epilepsy with mental deficiency			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **1-12-**, 19 **42**, to **12-27-**, 19 **55**, that I last saw the deceasedalive on **12-27-**, 19 **55**, and that death occurred at **9:55 A.** m., from the causes and on the date stated above.SIGNATURE **M. N. Mastin, M.D.** (Degree or title) ADDRESS **Springfield State Hosp.-Sykesville, Md.** DATE SIGNED **12-27-55**

23. BURIAL-CREMATATION REMOVAL (Specify)	DATE 12/31/55	NAME OF CEMETERY OR CREMATORY Central Ave	LOCATION (City, town, or county) BALTO	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE H. L. Redlich	24. FUNERAL DIRECTOR Funeral	ADDRESS Home	

MARGIN RESERVED FOR BINDING



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS-45C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11833

CERTIFICATE OF DEATH

11830

Reg. Dist. No. 75

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Marbleton</u>		LENGTH OF STAY (in this place) <u>6 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westminster</u>		27	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Longview Nursing Home</u>				STREET ADDRESS (If rural give location) <u>147 E. Green St</u>		1	
3. NAME OF DECEASED (Type or Print) <u>Ida</u> (First) <u>V.</u> (Middle) <u>Zile</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 30</u> 19 <u>55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Dec 21 1959</u>	
9. AGE last birthday <u>98</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Abraham Miller</u>		14. MOTHER'S MAIDEN NAME <u>Lidia Falbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Arthur M Zile, Westminster Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1. IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Arterio-Sclerotic Cardio-vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>---</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 21</u> , 19 <u>50</u> , to <u>Dec 30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>55</u> , and that death occurred at <u>11:41</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Joseph V. Burt M.D.</u>				ADDRESS (Street, city, town, state) <u>Westminster Md</u>		DATE SIGNED <u>Dec 30, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 2, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Waverly Cemetery</u>		LOCATION (City, town, or county) (State) <u>Worfield Carroll Co. Md.</u>	
24. REC'D BY REGISTRAR <u>Jan 31-56</u>		REGISTRAR'S SIGNATURE <u>W. H. P. Sencer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers Jr.</u>		ADDRESS <u>Westminster, Md.</u>	

CERTIFICATE OF DEATH

1953

1. Name of deceased (Print or type)

JOHN J. GARELLI
Age 45
Sex Male
Race Italian

2. Date of death

January 10, 1953

3. Place of death

1000 North ...

4. Cause of death (List all causes)

Myocardial infarction
due to atherosclerosis
of the coronary arteries

5. Signature of physician

Dr. ...

6. Signature of registrar

...

7. Signature of coroner

...

RECEIVED
JAN 4 1956
BUREAU V. S.